Interpretive Guidelines and Survey Procedures for the Application of the Conditions of Participation for Skilled Nursing Facilities 20CFR Part 405

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
Health Care Financing Administration
Health Standards and Quality Bureau

APPENDIX A

Interpretive Guidelines and Survey Procedures for the Application of the Conditions of Participation for Skilled Nursing Facilities 20CFR Part 405

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INTERPRETIVE GUIDELINES AND SURVEY PROCEDURES FOR THE APPLICATION OF THE CONDITIONS OF PARTICIPATION FOR SKILLED NURSING FACILITIES

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Interpretive Guidelines and Survey Procedures for the Application of Conditions of Participation for Skilled Nursing Facilities (SNFs)

Introduction

These interpretive guidelines and survey procedures are multipurpose in design. They have been promulgated primarily for use by the State survey agency, the State Medicaid agency, and the providers, but it is hoped that they will also be of value to organizations and citizens who are concerned about the care provided to our institutionalized elderly. They include conditions of participation, national interpretation of the regulations, and suggestions for surveying. The interpretive guidelines assist in the understanding of the requirements and goals necessary for participation in the Medicare and Medicaid program.

The regulations, interpretive guidelines, and survey procedures should be viewed and used simultaneously. Often, elements in the standards are not repeated in the interpretive guidelines because these elements are self explanatory. Where clarification of a standard is needed, an interpretation has been supplied. It is important to remember that the interpretive guidelines do not represent all elements involved in the regulations, but only those elements where clarification seemed appropriate. Also, in evaluating compliance with specific standards, the surveyor must utilize the definitions of qualifications of personnel and terms used in the standards that are in Section 405.1101, (see Section 100 of this Appendix). For example, to determine if the dietitian consultant meets the requirements of the standard, the surveyor should refer to § 405.1101(f) for a definition of the qualifications for this position.

The surveyor is to evaluate the situation as it exists and exercise his judgment in determining if a condition is in compliance with the regulations. Often, the interpretive guidelines specify a particular number or condition not found in the standards themselves. Such specificities are accompanied by such terms as "it is recommended" or "at least" to convey that these are recommendations, and are not the final consideration in determining compliance. For example, the specificity in interpretive guidelines § 405.1134(j)(3), that the heating system be capable of maintaining a comfortable temperature at least 3 feet above the floor, does not necessitate noncompliance when the heat at a 2 1/2 foot level is comfortable. The intent is for a comfortable heat level, not the specific measurement. The measurement is simply an acceptable point at which the requirement may be judged.

The frequency and duration of consultation are not specified in the standards requiring the use of qualified consultants. Requiring a specific number of hours or visits does not assure effective or quality consultation. In such cases, interpretive guidelines may recommend a minimal number of hours considered desirable for consultation. However, the surveyor must decide if the time spent in the facility by the consultant is sufficient. A well-run dietetic service may require few hours of consultation a month, depending upon such factors as staff capabilities, training, and the cooperation of the administrator of the facility in implementing a consultant's recommendations. Conversely, if a poorly run dietetic service is observed, although consultation is frequent, the problem may be in the quality of the consultation, or may be due to the administrator's refusal to implement the consultant's recommendation, or to some other cause. Thus, the end product, the quality of the service in question, must be the determining factor, not just the number of hours a consultant spends in the facility.

A number of the standards state that the facility should have established procedures to implement the requirements in the standard. This is not to be confused with the policy of a facility. The distinction between a policy and a procedure is that a policy is the principle upon which decisions governing the operation of the facility are based; a procedure is the method by which that policy is carried out. For example, a facility may develop a policy that states that only the individual prescription system shall be used in the facility. The procedure for accomplishing that policy would explain how the physician's prescription order is transmitted to the pharmacy, what is expected of the pharmacist in dispensing the drug, how the dispensed drug is delivered to the nursing station, etc.

Frequently, in the survey procedures, the surveyor is directed to interview facility personnel to obtain sufficient information to make his final recommendations. While interviews with the administrator, or the director of nursing, must necessarily be in depth, the surveyor need not disrupt the facility by protracted interviews of all the staff. A few well-phrased questions to many of the staff will elicit the desired information. At all times, the surveyor must strive to be an effective interviewer. Questions should be put in plain language; for example, to determine if a staff member is aware of disaster procedures and his role in such events, a surveyor may simply ask, "If you smelled smoke, what would you do?" The response to this question will provide valuable insights into the adequacy of training in disaster preparedness.

Questions should also be directed to the appropriate personnel. If the facility has established procedures, with designated staff responsible for particular functions, as for example, if administration of medications is restricted to certain staff, questions should be directed only to the personnel charged with this responsibility. Likewise, unless there is a resident in isolation, the staff should know that there are isolation procedures and where they are located but do not have to be familiar with them.

In conducting the survey, simple rules of courtesy apply. In obtaining information, the surveyor strives for objectivity, and avoids emotional confrontations. His role as surveyor is tempered by his role as consultant to the facility. In short, he is a professional. The conditions of participation, and the certification process are designed to upgrade the level of care. The surveyor is the embodiment of these Federal aims and should conduct himself accordingly. These interpretive guidelines and survey procedures are created to assist him in accomplishing his assignments in an acceptable, professional manner.

STANDARD	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
405.1120 Condition of participation--compliance with Federal, State, and local laws. The skilled nursing facility is in compliance with applicable Federal, State, and local laws and regulations. (a) Standard: Licensure. The facility, in any State in which State or applicable local law provides for licensing of facilities of this nature: (1) Is licensed pursuant to such law; or (2) If not subject to licensure, is approved by the agency of the State or locality responsible for licensing skilled nursing facilities as meeting fully the standards established for such licensing, and (3) Except that a facility which formerly met fully such licensure requirements, but is currently determined not to meet fully all such requirements, may be recognized for a period specified by the State standard-setting authority.	405.1120 Compliance with Laws (a) Standard 1. The facility's current license is available. 2. If the facility is not subject to licensure, a letter of approval from the licensing agency stating that all standards in licensure regulations are met is available.	405.1120 - Compliance with Federal, State, and local laws. (a) Standard 1. The surveyor verifies at the time of each survey and prior to certifying the facility, that it holds a current license. In instances where State licensure or approval is provisional or temporary, the surveyor documents the reason for the status, any limitations imposed on the operation, and how they affect the certification. 2. Some States have facilities that are exempt from the licensure law (i.e., official agencies). In those States the surveyor checks that the facility has been certified by the State licensure agency as meeting the standards for licensure even though it is not in fact licensed.

STANDARD	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
(b) Standard: Licensure or registration of personnel. Staff of the facility are licensed or registered in accordance with applicable laws.	(b) Standard 1. Current licensure or registration numbers of all applicable personnel are available at the facility. 2. The facility has a written procedure for verification of valid licensure or registration at the time of employment and at regular intervals thereafter.	(b) Standard 1. The surveyor verifies that there is an established procedure for verification of a valid license or registration number at the time of employment and annually thereafter. 2. A random sample of the personnel files is checked to see if the current licensure information is on file. 3. When verification of state licensure or registration is not available for foreign and/or out of state personnel employed in the facility, the surveyor contacts the appropriate State licensure board for verification of credentials.
(c) Standard: Conformity with other Federal, State, and local laws. The facility is in conformity with all Federal State, and local laws relating to fire and safety, sanitation, communicable and reportable diseases, postmortem procedures, and other relevant health and safety requirements.	(c) Standard 1. Current reports (e.g., sanitation and fire inspections) from all responsible governmental agencies are retained at the facility. 2. The facility has written policies and procedures for personnel hygiene, reporting communicable diseases, etc.	(c) Standard 1. The surveyor is familiar with the Federal, State, and local laws relating to health and safety requirements for skilled nursing facilities and compares these laws with the policies and procedures of the facility to ensure that all pertinent areas are covered, (e.g., a reporting mechanism for communicable diseases). 2. The most recent reports from inspection agencies are reviewed and a status report of actions taken is requested from the administrator wherever deficiencies or recommendations are made. 3. The surveyor reviews documentation on fire drills to validate the practice of these drills, the evaluations, and the participation by all shifts of personnel.

STANDARD	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
405.1121 Condition of participation--governing body and management.	405.1121 Governing body and management	405.1121 Governing body and management.
The skilled nursing facility has an effective governing body, or designated persons so functioning, with full legal authority and responsibility for the operation of the facility. The governing body adopts and enforces rules and regulations relative to health care and safety of patients, to the protection of their personal and property rights, and to the general operation of the facility. The governing body develops a written institutional plan that reflects the operating budget and capital expenditures plan.	The governing body is the policy making body of a facility, the board of directors or trustees of a corporation, or the owner(s), in the case of a proprietary facility.	The surveyor must evaluate not only the standards in this condition but also consider the effectiveness of the overall operation of the facility to determine compliance with this condition.
(a) Standard: Disclosure of ownership. The facility supplies full and complete information to the survey agency as to the identity (1) of each person who has any direct or indirect ownership interest of 10 per centum or more in such skilled nursing facility or who is the owner (in whole or in part) of any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by such skilled nursing facility or any of the property or assets of such skilled nursing facility, (2) in case a skilled nursing facility is organized as a corporation, of each officer and director of the corporation and (3) in case a skilled nursing facility is organized as a partnership, of each	(a) Standard Current articles of incorporation, partnership agreements, and other required legal documents are available in the facility or furnished by the facility to the State Survey agency. Such information includes the type of ownership (individual proprietor, corporation, partnership, etc.).	(a) Standard 1. The State Survey agency has the necessary information in its files relative to the ownership of a facility. In those instances where the facility is incorporated, files also contain the names and addresses of the corporate officers and of each person who has 10% or more interest in the ownership of the facility. In those instances where the facility is a partnership, the files contain the names and addresses of each partner. The surveyor reviews this information in the State file prior to conducting the survey and compares it with the data obtained during the onsite visit. 2. If articles of incorporation, interviews, etc., indicate that there has been a change in ownership which has not been conveyed to the State survey agency, the surveyor documents his findings and takes appropriate action in accordance with instructions in the State Operations Manual.

STANDARD	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
partner, and promptly reports any changes which would affect the current accuracy of the information so required to be supplied.		
(b) Standard: Staffing patterns. The facility furnishes to the State survey agency information from payroll records setting forth the average numbers and types of personnel (in full-time equivalents) on each tour of duty during at least 1 week of each quarter. Such week will be selected by the survey agency.	(b) Standard 1. The governing body is responsible for ensuring that the facility's records contain accurate staffing information as required by State law, and furnishes this information to the State. 2. The staffing report includes the patient census and a current listing of personnel by name, title, and total hours on duty per week. 3. The administrative personnel who contribute either directly or indirectly to patient services and the personnel who provide direct patient care and services are included. The administrative personnel who perform the managerial and financial functions are excluded. 4. If the facility is multi-story or includes more than one building, the staffing pattern for each floor and building is included.	(b) Standard 1. The surveyor reviews the last quarterly staffing report on file and verifies onsite, through review of the payroll records, the accuracy of the report. 2. The staffing is checked to ensure that it meets the State licensure requirements.

STANDARD	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
(c) Standard: Bylaws. The governing body adopts effective patient care policies and administrative policies and bylaws, governing the operation of the facility, in accordance with legal requirements. Such policies and bylaws are in writing, dated, and made available to all members of the governing body which ensures that they are operational, and reviews and revises them as necessary.	(c) Standard 1. The facility has available a copy of the formally adopted bylaws or its equivalent. An equivalent would be a charter, articles of incorporation, or an official statement of policies and objectives. Included in either should be written provisions that specify the following: a. The basis upon which members and officers of the governing body are selected, terms of office, duties, and responsibilities; b. The frequency of governing body meetings and a recording of the minutes; and c. The person responsible for direction and supervision of the facility's services and the methods established by the governing body for holding such person responsible. 2. The equivalent for a single unincorporated owner is an official statement of objectives and policies.	(c) Standard 1. In surveying for bylaws or an acceptable equivalent, the surveyor first looks for formally adopted bylaws, e.g., signed and dated by governing body, approved in minutes of meetings of the governing body. In facilities where there are no bylaws, the surveyor reviews the equivalent. 2. The bylaws or their equivalent are reviewed to verify that they are current and contain sufficient detail to cover the operation of the facility. 3. Minutes of appropriate facility committees (i.e., utilization review, infection control, patient care policy, etc.) are checked to see if their recommendations are forwarded to the governing body for action and if a record is made of the action taken.
(d) Standard: Independent medical evaluation (medical review). The governing body adopts policies to ensure that the facility cooperates in an effective program which provides for a regular program of independent medical evaluation and audit of the patients in the facility to the extent required by the programs in which the facility participates (including, at least annually, medical evaluation of each patient's need for skilled nursing facility care).	(d) Standard 1. The facility has policies and procedures that delineate the role and responsibilities of its staff in independent medical evaluation. 2. The results of independent medical evaluation are reported to the governing body, and minutes reflect that appropriate action is taken.	(d) Standard 1. The surveyor reads the policies and procedures pertaining to independent medical evaluation to ensure that they clearly delineate the facility's role in assisting the State team in the review process. 2. The reports of medical review team on file in the State Survey agency office are reviewed prior to the survey. During the survey, check to see whether the medical review team's recommendations, if any, have been implemented.

STANDARD	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
(e) Standard: Administrator. The governing body appoints a qualified administrator who is responsible for the overall management of the facility, enforces the rules and regulations relative to the level of health care and safety of patients, and to the protection of their personal and property rights, and plans, organizes, and directs those responsibilities delegated to him by the governing body. Through meetings and periodic reports, the administrator maintains ongoing liaison among the governing body, medical and nursing staffs, and other professional and supervisory staff of the facility, and studies and acts upon recommendations made by the utilization review and other committees. In the absence of the administrator, an employee is authorized, in writing, to act on his behalf.	(e) Standard 1. The administrator's license or current registration is available. 2. The administrator: a. Manages the ongoing functions of the facility through employment of adequate numbers of appropriately trained professional and auxiliary personnel and the appropriate delegation of duties; b. Ensures that public information describing the services provided in the facility is accurate and fully descriptive; c. Ensures each patient's right to fair and equitable treatment, self determination, individuality, privacy, property and civil rights, including the patient's right to lodge a complaint. 3. The administrator's responsibilities are described as follows: a. Is liable for implementation of established patient care policies, personnel policies, etc.; b. Serves as liaison to governing body, medical staff, and other professional and supervisory staff; c. Evaluates and implements recommendations from the facility's committees, e.g., utilization review, pharmaceutical services, infection control, etc; and	(e) Standard 1. The surveyor evaluates compliance with this standard not only in terms of this particular standard, but also in terms of efficiency of the total operation. 2. The administrator is interviewed to determine his knowledge of the services provided by the facility, the personnel, budgetary and fiscal practices, and contracts with other agencies or individuals. 3. The job description of the administrator is reviewed to ascertain if the governing body has delegated to him the responsibilities for the daily operations of the facility. 4. The policy manual is reviewed to ensure that patient's personal and property rights are included and that there is evidence in the record that the patient and/or his family have been informed of the policy. 5. The minutes of staff committee meetings are reviewed to verify that committee recommendations are acted upon. 6. The employee designated as the alternate for the administrator is interviewed to verify that he has full understanding of his responsibilities.

d. Maintains his professional status (i.e., periodic educational and professional activities as required by law).

4. An administrator is not prohibited by law from serving more than one facility, but sufficient time must be spent at each facility to ensure that all the functions of the administrator are effectively carried out.

STANDARD

(f) Standard: Institutional planning. The institutional plan:

(1) Provides for an annual operating budget which includes all anticipated income and expenses related to items which would, under generally accepted accounting principles, be considered income and expense items (except that nothing in this paragraph shall require that there be prepared, in connection with any budget, an item-by-item identification of the components of each type of an anticipated expenditure or income),

(2) Provides for a capital expenditures plan for at least a 3-year period (including the year to which the operating budget described in paragraph (1) of this section is applicable) which includes and identifies in detail, the anticipated sources of financing for, and the objectives of, each anticipated expenditure in excess of $100,000 related to the acquisition of land, the improvement of land, buildings, and equipment, and the replacement, modernization, and expansion of the buildings and equipment which would, under generally accepted accounting principles, be considered capital items,

(3) Provides for review and updating at least annually, and

INTERPRETIVE GUIDELINES

(f) Standard

The principle of institutional planning was incorporated to improve business practices of facilities by requiring management to become more knowledgeable and involved in the fiscal planning aspect of the operations.

1. Detailed budgets and operating plans containing the following are to be prepared annually:

   a. Services to be provided in the future;

   b. Estimated cost of providing such services;

   c. Proposed capital expenditures in excess of $100,000; and

   d. Proposed method of financing such costs.

2. The budget and operating plan must be prepared under the direction of the governing body of the institution and prepared by a committee consisting of representatives of that body and from the administrative and medical staff.

3. The plan covers the current and next two fiscal years.

A capital expenditure is a financial outlay which buys fairly permanent assets, e.g., new building, new wing to an existing building, a major piece of equipment, etc. Included under capital expenditures are:

a. Expenditures as described previously that amount to over $100,000;

b. Expenditures that change the bed capacity; or

c. Substantially change the services provided by the institution, e.g., therapy room.

SURVEY PROCEDURES

(f) Standard

The surveyor does not review the specifics in the operating plans or the budget, but verifies that:

1. Operating plans and budgets are prepared; and

2. The governing body and the administrative and medical staffs participate in the development of the operating plans and the budget.

STANDARD	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
(4) Is prepared, under the direction of the governing body of the institution, by a committee consisting of representatives of the governing body, the administrative staff, and the organized medical staff (if any) of the institution.		
(g) Standard: Personnel policies and procedures. The governing body, through the administrator, is responsible for implementing and maintaining written personnel policies and procedures that support sound patient care and personnel practices. Personnel records are current and available for each employee and contain sufficient information to support placement in the position to which assigned. Written policies for control of communicable disease are in effect to ensure that employees with symptoms or signs of communicable disease or infected skin lesions are not permitted to work, and that a safe and sanitary environment for patients and personnel exists and incidents and accidents to patients and personnel are reviewed to identify health and safety hazards. Employees are provided, or referred for, periodic health examinations, to ensure freedom from communicable disease.	(g) Standard 1. Written personnel policies, procedures, organization charts, and job descriptions are made available to and discussed with each employee. 2. Each employee receives or is referred for pre-employment and at least annual examinations that include tests and/or X-rays to verify the absence of active communicable diseases. 3. Each employee has a complete employment record which is kept confidential. This record contains: a. A dated application for employment which includes a resume of the applicant's training and experience and documentation that references were verified. b. Current employee health status report. c. Evaluations of work performance, in accordance with facility's policies.	(g) Standard 1. The surveyor reviews the job descriptions to verify that each service has a description for each employee classification as it applies to the facility. 2. With a combination of interview, observation, and review of assignments, the surveyor determines if employees are familiar with their job descriptions and are functioning within their scope. 3. The written personnel policies are reviewed to see that they include areas specifically required in the standard. 4. A sample of individual employee personnel files is checked for records of health examinations and performance evaluations as required by the policies of the facility.

STANDARD	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
(h) Standard: Staff development. An ongoing educational program is planned and conducted for the development and improvement of skills of all the facility's personnel, including training related to problems and needs of the aged, ill, and disabled. Each employee receives appropriate orientation to the facility and its policies, and to his position and duties. Inservice training includes at least prevention and control of infections, fire prevention and safety, accident prevention, confidentiality of patient information, and preservation of patient dignity, including protection of his privacy and personal and property rights. Records are maintained which indicate the content of, and attendance at, such staff development programs.	(h) Standard 1. The facility's staff development program is a planned and organized system of training that begins with orientation and continues throughout the duration of employment for all classifications of staff, and provides: a. An orientation program that includes discussion of management operation and administrative policies, the significance of the employee's contribution to and responsibility for good patient care, and the beginning of training to improve skills; b. Skills training that includes instructions on "how to do the job," that covers manual, behavioral, and communication skills; c. A continuing education program that is designed and developed for the specific needs or interests of the staff and permits the utilization of community resources; and d. Leadership training that includes the administrative and supervisory principles essential for charge nurses, supervisors, and other appropriate personnel. 2. Where possible, ample time is allowed for staff to attend outside workshops and continuing education programs. Staff members attending educational programs are included in determining the adequacy of staff. This does not, however, relieve the facility of its obligations to adequately provide services as required by these standards, e.g., if the Director of Nursing is participating in a training course, a registered nurse must be designated who is capable of performing the duties of the Director of Nursing.	(h) Standard 1. The schedule, content, and attendance records of the staff development program are reviewed to determine if it is designed to include personnel on all tours of duty and that the program is appropriate in terms of: a. Topics covered; b. Methods of instruction; c. Teaching aids; and d. Scheduling of personnel to attend class. 2. Records are reviewed and personnel interviewed to verify that the program is being implemented and that all new personnel have had or are in the process of receiving an orientation. 3. The policies governing attendance at meetings outside the facility are reviewed.

STANDARD	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
(i) Standard: Use of outside resources. If the facility does not employ a qualified professional person to render a specific service to be provided by the facility, there are arrangements for such a service provided by an outside resource--a person or agency that will render direct service to patients or act as a consultant to the facility. The responsibilities, functions, and objectives, and the terms of agreement, including financial arrangements and charges, of each such outside resource are delineated in writing and signed by an authorized representative of the facility and the person or agency providing the service. Agreements pertaining to services must specify that the facility assumes professional and administrative responsibility for the services rendered. The outside resource, when acting as a consultant, apprises the administrator of recommendations, plans for implementation, and continuing assessment through dated, signed reports, which are retained by the administrator for followup action and evaluation of performance. (See requirement under each service—405.1125 through 405.1132).	(i) Standard The facility has available a written agreement with any outside resource retained to advise the facility or to provide direct services to patients. The minimum terms of agreement specify the responsibilities of both the facility and the consultants, the qualifications of the consultants, a description of the type of service to be provided, and, where applicable, the amount of time to be given by the consultant to the facility, the method of payment, and the duration of the agreement.	(i) Standard 1. The surveyor reviews the written agreement to assure that it contains: a. Description of services to be provided; b. Responsibility of each consultant in terms of scope, limitations, and changes in service, supervision, and records; c. Method of reimbursement; d. Duration of agreement; e. Orientation and staff development responsibilities; f. Qualifications and health status requirements of staff providing service; and g. Date and signatures of an authorized representative of the outside resource and the administrator. 2. Samples of facility records are reviewed to verify that the services stipulated in the agreement are being provided. 3. The surveyor reviews documentation such as notes in the clinical records or minutes of patient care planning meetings, verifies that communications between the outside resource and the staff of the facility are frequent and contain all information necessary to assure that the facility has the ultimate responsibility for the care of the patients.

STANDARD	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
(j) Standard: Notification of changes in patient status. The facility has appropriate written policies and procedures relating to notification of the patient's attending physician and other responsible persons in the event of an accident involving the patient, or other significant change in the patient's physical mental, or emotional status, or patient charges, billings, and related administrative matters. Except in a medical emergency, a patient is not transferred or discharged, nor is treatment altered radically, without consultation with the patient or, if he is incompetent, without prior notification of next of kin or sponsor.	(j) Standard 1. The next of kin is the patient's family and the "sponsor/conservator" is the agency and/or the person(s) other than the patient, responsible for the financial affairs of the patient. 2. The administrator is responsible for ensuring that the policies and procedures are clear, disseminated to the staff, and that related duties are appropriately delegated.	(j) Standard 1. The written policies and procedures are read to ensure that the specific requirements in the standard are included. 2. The incident reports, medical records, and other pertinent documents are reviewed to determine if the policies and procedures are being implemented. 3. State agency complaint files are checked for follow-up on specific patient complaints.

STANDARD

405.1121 Condition of Participation--Governing Body.

(k) Standard: Patients' rights. The governing body of the facility establishes written policies regarding the rights and responsibilities of patients and, through the administrator, is responsible for development of, and adherence to, procedures implementing such policies. These policies and procedures are made available to patients, to any guardians, next of kin, sponsoring agency(ies), or representative payees selected pursuant to section 205(j) of the Social Security Act, and Subpart Q of Part 404 of this chapter, and to the public. The staff of the facility is trained and involved in the implementation of these policies and procedures.

INTERPRETIVE GUIDELINES

1. The written policies reflect a clear statement of how patients are to be treated by the facility, its personnel, volunteers, and others involved in providing care. They are accompanied by procedures for implementing and ensuring such treatment in practice and identifying personnel with primary responsibility for implementing the policies.

2. "Responsibilities of patients" refers to the rules and regulations governing individual patients in their dealings with the facility, staff, and other patients. The rules and regulations governing patient behavior cannot limit the rights of patients as set forth in this standard.

3. In developing these policies and procedures, the governing body should seek the advice of staff, patients, relatives, and community groups to assure that they are meaningful and relevant.

4. A written copy of the facility's policies and procedures regarding patients rights and responsibilities is available upon request.

5. The facility informs patients, relatives, guardians, or sponsoring agencies of the availability of these policies and procedures and of any changes. 405.1121(k)(1) gives further guidelines on this matter.

SURVEY PROCEDURES

1. Prior to the on-site survey the surveyor reviews the facility file at the State Agency to identify any complaints made against the facility regarding the violation of any of the patient rights covered in this standard. Particular attention should be paid to any areas of alleged violation.

2. The surveyor reviews the facility's policy and procedure manual(s) to verify that they contain both policy and procedural statements concerning patient and personnel responsibilities and at least those patient rights of this standard, and verifies that the policies and procedures are implemented.

3. The surveyor:

   a. Reviews content of staff development program to assure that it covers patients' rights;

   b. Checks the attendance records to verify that all employees have participated; and

   c. Questions the personnel to determine if they understand their role in the implementation of these policies.

STANDARD	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
	6. The facility's policies and procedures regarding patients' rights and responsibilities are formally included in the ongoing staff development program (405.1121(h)) for all personnel, including new employees.	
	7. The staff are knowledgeable of these policies and procedures and understand their roles in the implementation. This requires an understanding of the values and philosophy underlying patients' rights and responsibilities and continuing supervisory support and guidance.	

STANDARD	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
These patients' rights policies and procedures ensure that, at least each patient admitted to the facility: (1) Is fully informed, as evidenced by the patient's written acknowledgment, prior to or at the time of admission and during stay, of these rights and of all rules and regulations governing patient conduct and responsibilities;	1. It is important that a patient understands what he can expect from the facility and its staff, and what they expect from him. The facility, therefore, has clearly defined policies and procedures for communicating these expectations during the period of not more than two weeks before or 5 work days after admission, unless medically contraindicated in writing. Such communication is in writing (e.g., in a brochure describing the facility or in a separate handout) and interpreted verbally (e.g., as part of a pre-admission interview, patient counseling, or in individual or group orientation sessions following admission). 2. Patients' rights and responsibilities are presented in language understandable to the patient. If the facility serves patients who are non-English speaking or deaf, steps are taken to translate the information into a foreign or sign language. In the case of blind patients, either braille and/or a recording is provided. Patients should be encouraged to ask questions about their rights and responsibilities and these questions should be answered. 3. **A statement is signed by the patient, unless medically contraindicated in writing, indicating an understanding of these rights and responsibilities, and is maintained in the patient's record. Facility policies should indicate that such a statement is signed by the patient no later than 5 days after admission.** 4. In order to ensure that patients continue to be aware of these rights and responsibilities during their stay, written copies are prominently posted in locations that are available to all patients (e.g., patient rooms, lobby, lounge, or activities area)	1. Surveyor reviews written materials that inform patients of their rights and responsibilities and verifies that they are prominently posted. 2. Procedures for verbally informing patients are reviewed for content and identification of the facility staff member(s) assigned this function. Such staff are interviewed to verify their knowledge of patients' rights and their ability to communicate it in language understandable to patients. 3. A number of patient records are checked to verify: a. That patients have signed a form indicating understanding of their rights and responsibilities within 5 work days after admission; and b. When a patient is medically or legally unable to understand this information, the patient's guardian or responsible relative has been informed on the patient's behalf. 4. A sample of patients who indicated their understanding are interviewed to verify their understanding.

STANDARD	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
	5. All patients are advised promptly of changes in the statement of patients' rights and responsibilities. Appropriate means are utilized to inform non-English speaking, deaf, or blind patients of such changes.	

STANDARD	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
(2) Is fully informed, prior to or at the time of admission and during stay, of services available in the facility, and of related charges including any charges for services not covered under titles XVIII or XIX of the Social Security Act, or not covered by the facility's basic per diem rate;	1. The facility makes available to patients, and explains as necessary, a list of the kinds of services and articles provided by the facility. The list identifies nursing care, professional services, and supplies, as well as recreation and personal care services and items (e.g., laundry, cosmetics, beautician services, haircuts, etc.). Charges for all services and supplies not included in the facility's basic per diem rate are identified. Items covered under Medicare and/or Medicaid are clearly indicated, as well as all items that will be charged directly to the patient. These will be reviewed with the patient by a designated staff member. 2. Patients are informed in advance of any changes in the costs or availability of services.	1. The list of services and supplies is reviewed to verify that it reflects the facility's practices and identifies items not covered in the per diem rate or by Medicare/Medicaid. (Items covered by Medicare/Medicaid are described in a program leaflet, "Medicare Benefits in a Skilled Nursing Facility.") 2. Patients are interviewed to determine that they understand services and supplies available and their fiscal responsibilities, if any. 3. A list of services provided under the Medicaid program should be available to surveyors from the state survey agency.

STANDARD	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
(3) Is fully informed, by a physician, of his medical condition unless medically contraindicated (as documented, by a physician, in his medical record), and is afforded the opportunity to participate in the planning of his medical treatment and to refuse to participate in experimental research;	1. The policy that patients be informed of their conditions, involved in the planning of their care, and advised of any significant changes in either, is discussed with every physician responsible for the medical care of patients in the facility. 2. The medical director is responsible for working with attending physicians in the implementation of this policy. **3. If it is determined that informing patients of their condition is medically contraindicated, this decision and reasons for it are documented in the patient's record.** **4. The planned regimen of medical care and the discharge plan (ref.: 405.1137 h) developed by the physician and other staff upon admission includes participation by the patient. Patients are advised of alternative courses of care and treatment and their consequences when such alternatives are available. The patient's preference about alternatives should be elicited and considered in deciding on the plan of care.** **5. Total patient care includes, but is not limited to, medical care, nursing care, nutritional care, rehabilitation and restorative therapies.** **6. A patient being considered for participation in experimental research must be fully informed of the nature of the experiment (e.g., medication, treatment) and understand the possible consequences of participating or not participating. The patient's written consent must be received prior to participation.**	1. The surveyor verifies through the interview of a number of patients to determine whether their plan of care has been discussed with them and whether they have had the opportunity to participate in planning. 2. Medical records of a sample of patients who have not been informed of their conditions are checked to verify the physician's statement of medical contraindication. 3. The surveyor determines whether any patients are participating in experimental research and interviews them about their knowledge and awareness of the experiment.

STANDARD	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
(4) Is transferred or discharged only for medical reasons, or for his welfare or that of other patients, or for non-payment for his stay (except as prohibited by Titles XVIII or XIX of the Social Security Act), and is given reasonable advance notice to ensure orderly transfer or discharge, and such actions are documented in his medical record;	1. The term "transfer" applies to the movement of a patient from one location to another within a facility, as well as movement to another facility. 2. "Medical reasons" for transfer or discharge are based on the patient's needs and are determined and documented by a physician. Movement may be required to provide a different level of care. 3. "Welfare" of a patient or that of other patients refers to their social or emotional well being. This is a complex concept in that assessment can vary with each individual patient, facility, and surveyor. An example of moving a patient for his welfare is to facilitate visits by relatives and friends. A patient might also be transferred or discharged because his behavior poses a continuing threat to himself (i.e., suicidal) or to the well being of other patients (e.g., his behavior is incompatible with their needs and rights). 4. Non-payment for services rendered may be a legitimate reason for transfer or discharge. However, it is important to note that Title XVIII and XIX have special regulations dealing with patients' fiscal responsibilities.	1. The surveyor reviews policies and procedures regarding transfer and discharge, and the mechanism for providing the patient reasonable advance notice, and verifies that they are implemented.

5. "Reasonable advance notice" means that the decision to transfer or discharge a patient must be discussed with him, and that he be told the reasons for it and alternatives available, far enough in advance -- for moves of a patient from one location to another within the facility, the patient should be given at least 24 hours advance notice -- so that he may make his wishes known and participate in the planning for the move.

6. Section 405.1121(j) also deals with this subject, including emergency situations.

STANDARD	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
(5) Is encouraged and assisted, throughout his period of stay, to exercise his rights as a patient and as a citizen, and to this end may voice grievances and recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal;	1. The facility provides ongoing opportunities for patients to be aware of and exercise their rights as patients. Patients are kept informed of issues or pending decisions of the facility that affect them and their views are solicited prior to action. 2. Rights as a citizen refers to all the rights of citizens of this country and any particular State or locality. These include, but are not limited to: voting, marriage, and divorce, executing instruments (e.g., wills), acquiring and disposing of property, and choosing to practice or not to practice a religion. Some of the ways in which the facility may assist patients in exercising these rights are identifying and obtaining services from community legal and social agencies, registering absentee ballots, etc. 3. The facility has a written procedure for registering and resolving grievances and recommendations by patients or any individual or group designated by the patient as his representative. The procedure ensures protection of the patient from any form of reprisal or intimidation. The written procedure includes: a. Designation of an employee responsible for handling grievances and recommendations; b. A method of investigating and assessing the validity of a grievance or recommendation; c. Methods of resolving grievances; and d. Methods of recording grievances and actions taken.	The surveyor: 1. Reviews the facility's policy and procedure(s) for encouraging and assisting patients to exercise their rights; 2. Reviews the facility's procedure for dealing with patient grievances and recommendations; 3. Examines records of grievances and actions taken; and 4. Interviews patients who have complained and employee responsible for handling grievances to verify resolutions and protection of patients from reprisals.

4. One method of involving patients in exercising their rights is the organization and support of a patient council, which would provide a forum for discussion of issues and a channel of communication between the patient body and the facility.

STANDARD	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
(6) May manage his personal financial affairs or be given, at least quarterly, an accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility for any period of time, in conformance with State law;	1. The facility maintains a written account of all patients' funds received by or deposited with the facility. 2. An employee is designated to be responsible for patient accounts. 3. The facility may, at the patient's request, keep on deposit personal funds over which the patient has control. Should the patient request these funds, they are given to him on request with receipts maintained by the facility and a copy to the patient. 4. If the facility makes financial transactions on a patient's behalf, the patient receives or acknowledges that he has seen, an itemized accounting of disbursements and current balances at least quarterly. A copy of this statement is maintained in the patient's financial or business record.	The surveyor: 1. Reviews the policies and procedures pertaining to patient accounts and verifies that they are being followed. 2. Interviews a sample of patients to determine whether they: a. Have access to any personal funds held by the facility; b. Know the current status of their accounts; and c. Receive, and have explained if necessary, at least quarterly accountings of transactions made on their behalf.

STANDARD

7) Is free from mental and physical abuse, and free from chemical and (except in emergencies) physical restraints except as authorized in writing by a physician for a specified and limited period of time, when necessary to protect the patient from injury to himself or to others;

INTERPRETIVE GUIDELINES

1. Mental abuse includes, but is not limited to, humiliation, harrassment, and threats of punishment or deprivations.

2. Physical abuse refers to corporal punishment and the use of restraints as a punishment.

3. Drugs such as tranquilizers may not be used to limit or control patient behavior for the convenience of staff. (405.1124(h) and 405.1127(d)).

4. Physical restraint includes the use of such devices as posey belts, wrist or ankle cuffs, blanket restraints, bed nets, and prolonged confinement to a geriatric chair.

5. **Physical restraints are not to be used to limit patient mobility for the convenience of staff, and must comply with life safety requirements. If a patient's behavior is such that it will result in injury to himself or others and any form of physical restraint is utilized, it should be in conjunction with a treatment procedure designed to modify the behavioral problems for which the patient is restrained or, as a last resort, after failure of attempted therapy.**

SURVEY PROCEDURES

1. The facility's policies and procedures regarding mental and physical abuse are reviewed and the surveyor verifies that they are being followed.

2. The surveyor observes and talks with patients to determine whether they:

   a. Feel free to relate complaints or abuses;

   b. Seem open and secure in talking about their treatment as individuals; and

   c. Are fearful or unwilling to assess how they are treated.

3. The surveyor:

   a. Reviews policies and procedures governing the use of chemical and physical restraints,

   b. Identifies some patients who are under restraint; and

   c. Verifies that appropriate procedures are followed.

6. The written policy and procedures governing the use of restraints specify which staff member may authorize the use of restraints and clearly delineate at least the following:

   a. Orders indicate the specific reasons for the use of restraints;

   b. Their use is temporary and the patient will not be restrained for an indefinite amount of time;

   c. Orders for restraints shall not be enforced for longer than 12 hours, unless the patient's condition warrants;

   d. A patient placed in the restraint shall be checked at least every 30 minutes by appropriately trained staff and an account is kept of this surveillance;

   e. Reorders are issued only after a review of the patient's condition.

   f. Their use is not employed as punishment, for the convenience of the staff, or as a substitute for supervision;

   g. Mechanical restraints avoid physical injury to the patient and provide a minimum of discomfort;

   h. The opportunity for motion and exercise is provided for a period of not less than 10 minutes during each 2 hours in which restraints are employed, except at night; and

   i. The practice of locking patients in their rooms or using locked restraints also constitutes physical restraint and must be in conformance with the requirements of the Life Safety Code as well as meet the requirements contained in this standard.

STANDARD	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
(8) Is assured confidential treatment f his personal and medical records, and ay approve or refuse their release to ny individual outside the facility, ex- ept, in case of his transfer to another ealth care institution, or as required by aw or third-party payment contract;	1. The facility limits access to any medical records to staff and consultants providing professional service to the patient. (405.1132(b)) This is not meant to preclude access by representatives of state and federal regulatory agencies. 2. Similar procedures safeguard the confidentiality of patients' personal records (e.g., financial records and social services records 405.1120(c)). Only those personnel concerned with the fiscal affairs of the patients have access to the financial records.	The surveyor determines that the facility has procedures to safeguard the confidentiality of all patient records and that these procedures are followed.

STANDARD	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
(9) Is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs;	1. Staff display respect for patients when speaking with, caring for, or talking about them, as constant affirmation of their individuality and dignity as human beings. 2. Schedules of daily activities allow maximum flexibility for patients to exercise choice about what they will do and when they will do it. Patients' individual preferences regarding such things as menus, clothing, religious activities, friendships, activity programs, entertainment are elicited and respected by the facility. 3. Patients are examined and treated in a manner that maintains the privacy of their bodies. A closed door or a drawn curtain shields the patient from passers-by. People not involved in the care of the patients are not present without their consent while they are being examined or treated. 4. Privacy of a patient's body also is maintained during toileting, bathing, and other activities of personal hygiene, except as needed for patient safety or assistance.	The surveyor: 1. Observes facility personnel as they interact with patients to determine whether behavior is respectful of patients as human beings. 2. Checks daily activity schedules to ascertain which patients are offered options and whether individual preferences are elicited. 3. Questions patients to assure that they have participated in the decision making process. 4. Verifies that the facility ensures the privacy of patients during treatment and personal care.

STANDARD	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
(10) Is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care;	1. Patients are not used to provide a source of labor for a facility against their will or against their physicians' orders. 2. If the plan of care requires such activities for therapeutic reasons, the plan for these activities is professionally developed and implemented, the therapeutic goals are clearly stated and measurable, the plan is time limited and reviewed at least quarterly.	1. The surveyor determines that any patient doing work for the facility does so: a. Voluntarily; b. With the approval of the physician; and c. In accordance with therapeutic goals and professional supervision as reflected in the plan of care.

STANDARD	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
(11) May associate and communicate privately with persons of his choice, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician in his medical record);	1. Policies and procedures recognize the needs of patients to have access to and maintain contact with the community of which they are a part and members of that community have access to him. 2. Subject to reasonable scheduling restrictions, visiting policies and procedures permit patients to receive visits from anyone they wish. A particular visitor may be restricted by the facility for one of the following reasons: a. The patient refuses to see the visitor. b. The patient's physician documents specific reasons why such a visit would be harmful to the patient's health. c. **The visitor's behavior is unreasonably disruptive of the functioning of the facility (this judgment must be made by the administrator and the reasons are documented and kept on file).** 3. Decisions to restrict a visitor are reviewed and reevaluated each time the patient's plan of care and medical orders are reviewed by the physician and nursing staff or at the patient's request. 4. Space is provided for patients to receive visitors in reasonable comfort and privacy.	1. Visiting policies are reviewed to verify that they are not restrictive. 2. The surveyor talks with patients to verify that their personal mail is sent and received unopened. 3. The surveyor determines that telephones are available and accessible for patients' use.

5. Telephones, consistent with ANSI standards (405.1134(C)), are available and accessible for patients to make and receive calls with privacy. Patients who need help are assisted in using the phone. The fact that telephone communication is possible, as well as any restrictions, is made known to patients.

6. Arrangements are made to provide assistance to patients who require help in reading or sending mail.

STANDARD	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
(12) May meet with, and participate in activities of, social, religious, and community groups at his discretion, unless medically contraindicated (as documented by his physician in his medical record);	1. Patients who wish to meet with or participate in activities of social, religious, or other community groups in or outside of the facility are informed and encouraged and assisted to do so. (405.1131(b)). 2. All patients have the freedom to refuse to participate in these activities.	1. The surveyor reviews patient activities policies to verify that patients have opportunities to participate in activities of community groups and the freedom to refuse to do so.

STANDARD	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
(13) May retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other patients, and unless medically contraindicated (as documented by his physician in his medical record); and	1. Patients are permitted to keep reasonable amounts of personal clothing and possessions for their use while in the facility and such personal property is kept in a safe location which is convenient to the patient. 2. Patients are advised, prior to or at admission, of the kinds and amounts of clothing and possessions permitted for personal use, and whether the facility will accept responsibility for maintaining these items (e.g., cleaning and laundry). 3. Any personal clothing or possessions retained by the facility for the patient during his stay is identified and recorded on admission and a receipt given to the patient. The facility is responsible for secure storage of such items, and they are returned to the patient promptly upon request or upon discharge from the facility.	1. The surveyor reviews the policy identifying the kinds and amounts of personal clothing and possessions patients may keep and use and verifies that this policy is implemented and is not restrictive. 2. The surveyor verifies that patient possessions retained by the facility are identified, accounted for, and securely stored.

STANDARD	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
(14) If married, is assured privacy for visits by his/her spouse; if both are in-patients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician in the medical record).	1. The facility has a method of arranging for privacy in visits between spouses. 2. Spouses who are patients in the same facility are permitted to share a room unless one of their physicians documents in the medical record those specific reasons why such an arrangement would have an adverse effect on the health of the patient.	1. The surveyor verifies whether there is a method for arranging for private visits between spouses and talks to patients to determine if the policy is implemented. 2. The surveyor verifies that there is a policy which permits married patients to share a room and that the policy is implemented.
All rights and responsibilities specified in paragraphs (k)(1) through (4) of this section as they pertain to (a) a patient adjudicated incompetent in accordance with State law, (b) a patient who is found, by his physician, to be medically incapable of understanding these rights, or (c) a patient who exhibits a communication barrier--devolve to such patient's guardian, next of kin, sponsoring agency(ies), or representative payee (except when the facility itself is representative payee) selected pursuant to section 205(j) of the Social Security Act and Subpart Q of Part 404 of this chapter.	The fact that a patient has been adjudicated incompetent, is medically incapable of understanding, or exhibits a communication barrier, does not absolve the facility from advising the patient of these rights to the extent the patient is able to understand them. If the patient is incapable of understanding these rights, the facility advises the guardian or sponsor and acquires a statement indicating an understanding of patients' rights.	1. The surveyor reviews a sample of records of patients who are classified either incompetent, medically incapable of understanding their rights, or have a communication barrier to verify documented evidence (signed acknowledgment) that the guardian or other sponsor has been advised of these patient rights and understand their role in acting on behalf of the patient.

(1) Standard: Patient care policies. The skilled nursing facility has written patient care policies to govern the continuing skilled nursing care and related medical or other services provided.

(1) The facility has policies, which are developed by the medical director or the organized medical staff (see § 405.1122), with the advice of (and with provision for review of such policies from time to time, but at least annually, by) a group of professional personnel including one or more physicians and one or more registered nurses, to govern the skilled nursing care and related medical or other services it provides. The policies, which are available to admitting physicians, sponsoring agencies, patients, and the public, reflect awareness of, and provision for, meeting the total medical and psychosocial needs of patients, including admission, transfer, and discharge planning; and the range of services available to patients, including frequency of physician visits by each category of patients admitted. These policies also include provisions to protect patients' personal and property rights. Medical records and minutes of staff and committee meetings reflect that patient care is being rendered in accordance with the written patient care policies, and that utilization review committee recommendations regarding the policies are reviewed and necessary steps taken to ensure compliance.

Policies guide and limit the activities and decisions of the staff as they fulfill the objectives of the facility. The establishment and enforcement of policies ensures that specific duties or functions are performed accurately and uniformly.

1. The facility has patient care policies for the following areas:

   a. Admission, transfer, and discharge policies, categories of patients accepted and not accepted;

   b. Physician services;

   c. Nursing services;

   d. Dietetic services

   e. Rehabilitative services;

   f. Pharmaceutical services;

   g. Diagnostic services;

   h. Care of patients in emergencies, e.g., communicable disease outbreak, critically ill, mentally disturbed, etc.;

   i. Dental services;

   j. Social services;

   k. Patient activities;

Compliance with this standard is dependent upon the evaluation of the implementation of patient care policies in each service and the overall operation of the facility.

1. The stated functions, composition, and frequency of meetings of the committee responsible for assisting with the development and review of the patient care policies are checked to determine if there is representation from the professional services provided by the facility including at least a physician and a registered nurse.

2. The minutes of the committee are read to verify that the meetings are held as stated and the policies are discussed, reviewed, and revised as necessary.

3. The policy manual is reviewed to see that there are dated policies covering areas identified in the standard.

4. As each service is surveyed, the surveyor verifies that the policies of that service are being implemented.

STANDARD	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
	l. Medical records; m. Transfer agreement; n. Utilization review; and o. Personal and property rights. **2. Patient care policies are in writing and available upon request.** 3. The policies for patient care shall be established by a group of professionals composed as described by the standard and shall include representatives from specialized services to provide input as necessary. 4. The professional group meets at least annually to review and revise patient care policies as necessary, and such action is reflected in the minutes.	
(2) The medical director or a registered nurse is designated, in writing, to be responsible for the execution of patient care policies. If the responsibility for day-to-day execution of patient care policies has been delegated to a registered nurse, the medical director serves as the advisory physician from whom she receives medical guidance. (See § 405.1122(b)).	1. The administrator is responsible for ascertaining that patient care policies are established, whereas the professional staff specified in the standard is responsible for implementation. The facility ensures that physicians are aware of patient care policies.	1. The surveyor checks to see that there is a written policy designating a person responsible for the execution of the patient care policies that delineate and delegate the authority necessary to carry out this function. Through discussion with this person, the surveyor determines if he/she is aware of the policies and his/her responsibilities. 2. If a registered nurse is responsible, the surveyor verifies that an advisory physician is available for consultation as needed.

STANDARD

405.1122 Condition of participation--medical direction.

The facility retains, effective not later than 12 full calendar months from December 2, 1974, pursuant to a written agreement, a physician, licensed under State law to practice medicine or osteopathy, to serve as medical director on a part-time or full-time basis as is appropriate for the needs of the patients and the facility. If the facility has an organized medical staff, the medical director is designated by the medical staff with approval of the governing body. A medical director may be designated for a single facility or multiple facilities through arrangements with a group of physicians, a local medical society, a hospital medical staff, or through another similar arrangement. The medical director is responsible for the overall coordination of the medical care in the facility to ensure the adequacy and appropriateness of the medical services provided to patients and to maintain surveillance of the health status of employees. (See 405.1911(b) regarding waiver of the requirement for a medical director).

INTERPRETIVE GUIDELINES

405.1122 - Medical Direction

The facility has available a written agreement with the physician who serves as medical director. The minimum terms of the agreement specify the responsibilities of both the facility and the medical director, a description of the types of service to be provided, the delineation of lines of communication, the amount of time to be given, the financial arrangements, duration of the agreement, and provision for periodic review.

1. If the facility has an organized medical staff:

   a. The medical director is designated by that group. A qualified member of the staff is eligible for appointment; and

   b. The medical director's primary function is to serve as liaison officer between administration and the medical staff.

2. The medical director coordinates medical care, maintains effective liaison with attending physicians, and implements methods to keep the quality of care under constant surveillance.

3. With the professional staff of the institution, the medical director participates in the development of written policies, rules, and regulations to govern the skilled nursing care and related medical and other health services provided. The medical director is responsible for seeing that these policies are executed and assures that these policies reflect an awareness of and provisions for meeting the total needs of the patients. (405.1121(1))

SURVEY PROCEDURES

405.1122 - Medical Direction

Until January 1, 1976, if the condition is not met, that portion of the survey report form should be marked "not applicable," and documented to indicate the status of compliance, notification to the administrator of the requirement, and a brief outline of the consultation given.

1. The surveyor reviews the agreement to ensure that it contains:

   a. Responsibilities of the medical director, in terms of defining the scope, amount and characteristics of the services provided, including specific responsibility for overall management and delivery of patient care services (405.1121(i));

   b. Description of services to be provided (job description):

      (1) Delineation of lines of communication with the administrator, director of nursing, and other professional and auxiliary personnel;

      (2) Delineation of responsibility to relationships with attending physicians, medical review, and survey teams, etc.

   c. Other factors including time, compensation, and length of agreement.

   d. Statement relating to patient referrals and financial arrangements. (This arrangement does not preclude the medical director from providing direct patient care under other financial arrangements).

STANDARD

INTERPRETIVE GUIDELINES

4. The medical director:

   a. Ensures that patients receive adequate services appropriate to their needs;

   b. Ensures that the medical regimen is incorporated in the patient care plan; (405.1124(d));

   c. Participates in staff meetings which include meetings such as infection control, pharmaceutical services, patient care policies, etc.;

   d. Implements methods that assure continuous surveillance of the health status of employees including freedom from infection, routine health examinations (405.1121(g) and 405.1125(f)); and

   e. Participates in in-service training program (405.1121(h)).

SURVEY PROCEDURES

2. The surveyor reviews the bylaws, rules, and regulations to determine that the document includes:

   a. Mechanism for approval of the medical director by the governing body after designation by the medical staff;

   b. Delineation of the administrative responsibilities of the medical director regarding the quality of medical care;

   c. Functions of the medical staff; and

   d. Procedures to assure adherence to rules and regulations.

3. If medical direction is through arrangement with an outside resource, the surveyor determines that the provisions for medical direction, as set forth in the bylaws, rules, and regulations, are implemented.

4. The surveyor reviews minutes of the meetings of the medical staff to identify:

   a. Medical director's involvement in committees;

   b. Actions of the medical staff regarding other standing committees, policies, and procedures; and

   c. Reports of accidents, incidents and/or problems relating to the entire patient care program, including discussion of and action on increased cases of morbidity or mortality, deficiencies found through inspections or surveys, etc.

STANDARD	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
		5. The surveyor talks with the director of nursing, other professional staff, and, when available, attending physicians, to determine the types of support, coordination, supervision, and availability of the medical director.

STANDARD

(a) Standard: Coordination of medical care. Medical direction and coordination of medical care in the facility are provided by a medical director. The medical director is responsible for the development of written bylaws, rules, and regulations which are approved by the governing body and include delineation of the responsibilities of attending physicians. Coordination of medical care includes liaison with attending physicians to ensure their writing orders promptly upon admission of a patient, and periodic evaluation of the adequacy and appropriateness of health professional and supportive staff and services.

INTERPRETIVE GUIDELINES

1. If there is an organized medical staff, there are bylaws, rules, and regulations developed by the medical director and approved by the governing body. In the absence of a medical staff, there are written rules and regulations which cover at least the following:

   a. Method for determining admitting privileges for physicians;

   b. Responsibilities of attending physicians and medical director; and

   c. Responsibilities of attending physicians as identified in the Conditions of Participation.

SURVEY PROCEDURES

(a) Standard

1. The surveyor talks with the administrator and professional staff to determine whether the medical director participates in the development, review, and revision of the bylaws, rules, and regulations.

2. If there is an organized medical staff, the surveyor reviews the medical staff bylaws, rules, and regulations for content to determine that they include as a minimum:

   a. Purpose of facility; and

   b. Procedures of policies governing actions of physicians relating to:

      (1) Attending privileges and responsibilities;

      (2) Admission and discharge policies;

      (3) Medical records;

      (4) Physician orders;

      (5) Frequency of visits to patients;

      (6) Emergency medical policies including standing orders;

      (7) Mortuary procedures and autopsies;

      (8) Consultation with other physicians; and

      (9) Procedures for denial of privileges.

STANDARD

(b) Standard: Responsibilities to the facility. The medical director is responsible for surveillance of the health status of the facility's employees. Incidents and accidents that occur on the premises are reviewed by the medical director to identify hazards to health and safety. The administrator is given appropriate information to help ensure a safe and sanitary environment for patients and personnel. The medical director is responsible for the execution of patient care policies in accordance with 405.1121(1).

INTERPRETIVE GUIDELINES

The medical director:

1. Participates in the formulation of written policies for reporting and control infectious diseases and oversees their implementation.

2. Reviews routinely incident and accident reports and recommends corrective action.

3. Evaluates and assists the administrator in implementing the recommendations from the facility's committees (e.g., utilization review, pharmaceutical services, infection control, etc.).

4. Reviews written reports of surveys and inspections and makes recommendations to the administrator.

SURVEY PROCEDURES

1. The surveyor reviews the agreement between the medical director and the facility to determine that assigned responsibilities include:

   a. Surveillance to assure quality patient care;

   b. Involvement in patient care policies;

   c. Surveillance of employee health status;

   d. Review of incident and accident reports and actions relating to prevention;

   e. Identification of potential or actual hazards to health, safety, and sanitation; and

   f. Coordination and followup of corrective action with appropriate staff.

2. The surveyor reviews procedures for communicating incident and accident reports, including the reporting of medication errors, to the medical director to assure his awareness of all contingencies.

3. The surveyor reviews a sample of incident and accident reports to determine that corrective action has been taken.

STANDARD

405.1123 Condition of participation--physician services.

Patients in need of skilled nursing or rehabilitative care are admitted to the facility only upon the recommendation of, and remain under the care of a physician. To the extent feasible, each patient or his sponsor designates a personal physician.

(a) Standard: Medical findings and physicians' orders at time of admission. There is made available to the facility, prior to or at the time of admission, patient information which includes current medical findings, diagnoses, and orders from a physician for immediate care of the patient. Information about the rehabilitation potential of the patient and a summary of prior treatment are made available to the facility at the time of admission or within 48 hours thereafter.

INTERPRETIVE GUIDELINES

405.1123 - Physician Services

(a) Standard

1. A referral form from the transferring facility is received in advance or at the time of the patient's admission, and includes current medical findings, diagnoses, and orders from a physician for the immediate care of the patient.

2. If medical orders are unobtainable on admission, the emergency care physician gives temporary orders until the attending physician can be reached.

3. Information on the rehabilitation potential (prognosis) of the patient and a summary of the course of treatment followed in the transferring facility are transmitted to the admitting facility within 48 hours after admission

4. For patients admitted directly from the community, the attending physician provides current medical findings, diagnosis, prognosis and orders for the immediate care of the patient.

SURVEY PROCEDURES

405.1123 - Physician services.

(a) Standard

1. The medical records of patients admitted to the facility within the two weeks prior to the survey are examined to ascertain if the required information, orders, etc. were obtained at the time of admission or within 48 hours after admission. If the number of newly admitted patients is not an adequate sampling, check the date of admission of approximately 10% of the patients and compare that date with the dates on the orders, medical data, etc. To arrive at a valid sample, the surveyor will determine the actual size of the sample based on the number of patients in the facility.

STANDARD	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
(b) Standard: Patient supervision by physician. The facility has a policy that the health care of every patient must be under the supervision of a physician who, based on a medical evaluation of the patient's immediate and long-term needs, prescribes a planned regimen of total patient care. Each attending physician is required to make arrangements for the medical care of his patients in his absence. The medical evaluation of the patient is based on a physical examination done within 48 hours of admission unless such examination was performed within 5 days prior to admission. The patient is seen by his attending physician at least once every 30 days for the first 90 days following admission. The patient's total program of care (including medications and treatments) is reviewed during a visit by the attending physician at least once every 30 days for the first 90 days, and revised as necessary. A progress note is written and signed by the physician at the time of each visit, and he signs all his orders. Subsequent to the 90th day following admission, an alternate schedule for physician visits may be adopted where the attending physician determines and so justifies in the patient's medical record that the patient's conditions does not necessitate visits at 30-day intervals. This alternate schedule does not apply for patients who require specialized rehabilitative services, in which case the review must be in accordance with 405.1126(b). At no time may the alternate schedule exceed 60 days	(b) Standard 1. The planned regimen of total care for each patient is based upon the attending physician's orders and covers medications, treatments, rehabilitative nursing and specialized rehabilitative services, diets, precautions related to activities undertaken by the patient, and plans for continuing care and discharge. This plan is reviewed and revised by the attending physician in consultation with professional personnel at intervals appropriate to the needs of the patient. 2. As a part of the medical evaluation, a physical examination is done on each patient within 48 hours after admission (unless performed within previous 5 work days), and the report becomes part of the patient's record. Attention is given to each patient's special needs, such as dietetic, sight, oral, speech, hearing, and foot problems, and emotional and social adjustment. 3. Once the attending physician determines that a patient need not be seen by him every 30 days, an alternate schedule of visits will be established. Justification for the decision is placed in the patient's medical record and is reviewed by the utilization review committee or the medical review team. 4. The physician visit requirement in this standard applies to all skilled nursing patients in the facility. The records of patients who do not require skilled nursing service should be so annotated by the physician.	(b) Standard 1. A sampling of the current medical records is reviewed to verify that: a. There is a physical examination completed as required by the standard or a copy of the hospital physical examination with a note from the attending physician authenticating the report. b. The physician has visited the patient every 30 days or has justified an alternate schedule and has written a progress note. c. There is a current diagnosis. 2. The minutes of the utilization review committee are checked to verify that the UR committee has reviewed any justification for alternate schedules of visits and has concurred or not concurred. In the case of noncurrence, the surveyor reviews the patient's record to see that the physician is visiting every 30 days. In cases of concurrence, the surveyor verifies that the appropriate State agency has been advised of the alternate schedule. 3. The policies covering physician's services are reviewed to see that they include: a. Requirements for physician visits; b. Physician supervision of patient; c. Physician orders; and d. Designation of a physician alternate.

STANDARD	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
between visits. If the physician decides upon an alternate schedule of visits of more than 30 days for a patient, (1) in the case of a Medicaid benefits recipient, the facility notifies the State Medicaid agency of the change in schedule, including justification, and (2) the utilization review committee or the medical review team (see § 405.1121(d)) promptly reevaluates the patient's need for monthly physician visits as well as his continued need for skilled nursing facility services (see § 405.1137(d)). If the utilization review committee or the medical review team does not concur in the schedule of visits at intervals of more than 30 days, the alternate schedule is not acceptable.		
(c) Standard: Availability of physicians for emergency patient care. The facility has written procedures, available at each nurses station, that provide for having a physician available to furnish necessary medical care in case of emergency.	(c) Standard 1. The names and telephone numbers of physicians to be called in the event of an emergency are posted. 2. Procedures are established that provide steps to be followed when the attending physician is not available.	(c) Standard 1. The surveyor verifies that the names and telephone numbers of the emergency physicians are posted at each nurses' station accompanied by procedures to be followed if a physician does not respond. 2. The charge nurse is interviewed to determine if she is aware of the procedures to be followed in an emergency. 3. The incident reports should be reviewed to determine if the emergency physician has been available when the attending physician cannot be reached.

STANDARD

405.1124 Condition of participation--nursing services.

The skilled nursing facility provides 24-hour service by licensed nurses, including the services of a registered nurse at least during the day tour of duty 7 days a week. There is an organized nursing service with a sufficient number of qualified nursing personnel to meet the total nursing needs of all patients in the facility. (See § 405.1911(a) regarding waiver of the 7 day registered nurse requirement).

(a) Standard: Director of nursing services. The director of nursing services is a qualified registered nurse employed full-time who has, in writing, administrative authority, responsibility, and accountability for the functions, activities, and training of the nursing services staff, and serves only one facility in this capacity. If the director of nursing services has other institutional responsibilities, a qualified registered nurse serves as her assistant so that there is the equivalent of a full-time director of nursing services on duty. The director of nursing services is responsible for the development and maintenance of nursing service objectives, standards of nursing practice, nursing policy and procedure manuals, written job descriptions for each level of nursing personnel, scheduling of daily rounds to see all patients, methods for coordination of nursing services with other patient services, for recommending the number and levels of nursing personnel to be employed, and nursing staff development (see § 405.1121(h)).

INTERPRETIVE GUIDELINES

405.1124 Nursing services

If the facility is on a 4 day, 40 hour work week, registered nurse services must still be provided at least 7 days a week.

(a) Standard

1. Director of nursing serves during the day tour, (5 days a week, generally totaling 40 hours per week) except when she deems it necessary to vary working hours to provide supervision.

2. The director of nursing services: (405.1101(g))

   a. Develops and periodically updates statements of philosophy and objectives that define the type of nursing care the facility proposes to provide. The objectives identify the importance of integrating both the plan of medical care and the plan of patient care;

   b. Develops and maintains nursing service policies and procedures to implement the program of care;

   c. Ensures that the total nursing needs of patients are met by assigning a sufficient number of qualified supervisory and supportive nursing personnel for each tour of duty;

SURVEY PROCEDURES

405.1124 - Nursing services.

(a) Standard

The following measures will assist the surveyor in determining if the director of nursing is fulfilling her responsibilities:

1. Interview the director of nursing services and her assistants;

2. Review the personnel folders of the director of nursing and charge nurses to ascertain if they meet the qualifications as set forth in 405.1101(c) and (g);

3. Read the job description of the director of nursing services to verify that the responsibility and authority for the nursing services is clearly delineated;

4. Verify that there is planned supervision of both personnel performance and patient care;

5. Check to determine if there is a master staffing pattern for nursing services;

STANDARD	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
	d. Participates in coordination of patient services through departmental and appropriate staff committee meetings (i.e., pharmacy, infection control, patient care policies, and utilization review). e. Cooperates with the administration in planning the staff development program that will upgrade the competence of the personnel. Specific attention is given to improving supervisory skills of the charge nurses, and the multi-disciplinary approach to patient care. f. Ensures that all nurses' notes are informative and descriptive of the nursing care provided and of the patient's response to care; g. Participates in planning and budgeting for nursing services; h. Reviews the nursing requirements of each patient admitted to the facility and assists the attending physician in planning for the patient's care; i. Assumes responsibility for maintaining her own professional competence through participation in programs of continuing education, e.g., nursing seminars, short term training courses; and j. Ensures that the philosophy and objectives are understood by nursing personnel. k. Establishes a procedure for ensuring that nursing personnel, including private duty nurses, have valid and current licenses as required by the State in which the facility is located (405.1120(b));	6. Review the philosophy, objectives, organization plan, job descriptions, and policy and procedures manual(s) to find out if they are applicable to this particular facility; 7. Talk with patients, personnel, and charge nurses to obtain their reaction to the type nursing service being provided; and 8. Determine if the director of nursing services or her representative participate on appropriate committees 405.1122(a), 405.1127(d), 405.1135(a), and 405.1137(b).

STANDARD	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
(b) Standard: Charge nurse. A registered nurse, or a qualified licensed practical (vocational) nurse, is designated as charge nurse by the director of nursing services for each tour of duty, and is responsible for supervision of the total nursing activities in the facility during each tour of duty. The director of nursing services does not serve as charge nurse in a facility with an average daily total occupancy of 60 or more patients. The charge nurse delegates responsibility to nursing personnel for the direct nursing care of specific patients during each tour of duty, on the basis of staff qualifications, size and physical layout of the facility, characteristics of the patient load, and the emotional, social, and nursing care needs of patients.	(b) Standard 1. The charge nurse: a. Makes daily patient visits to observe and evaluate physical and emotional status. b. Reviews medication cards for completeness of information, accuracy in the transcription of physician orders, and adherence to stop order policies. c. Reviews patient care plans for appropriate patient goals, problems, approaches, and revisions based on nursing needs. d. Delegates responsibilities for the direct care of specific patients to the nursing staff based on the needs of the patient, the physical arrangement of the facility, and the capability of the staff. e. Arranges schedule to allow time for supervision and evaluation of performance of all nursing personnel on the unit; and f. Keeps the director of nursing services informed of status of patients and other related matters through written reports and verbal communication. g. Provides direct patient care when needed.	(b) Standard The charge nurse must plan, supervise, and teach to ensure quality care. Therefore, the surveyor: 1. Checks the background, experience, and licensure of the charge nurse for compliance with requirements 405.1101(c); 2. Verifies that the staff development program includes content relevant to the functions of the charge nurse and that the charge nurses have or are in the process of attending these sessions; 3. Reviews the job description of the charge nurse to ascertain that her scope of responsibilities is clearly delineated and to see what additional duties (if any) are included in addition to being charge nurse; 4. Evaluates the capability of the charge nurse to fulfill her responsibilities in terms of the number and condition of patients and the number and classification of personnel under her supervision by: a. Determining the charge nurse's awareness of the conditions of the most seriously ill patients on her ward; b. Asking the charge nurse to outline the care being given to these patients; and c. Verifying the care by reviewing the medical record and observing patient care. 5. Interviews alert patients to determine if they "know" the charge nurse on each tour of duty.

STANDARD	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
(c) Standard: Twenty-four-hour nursing service. The facility provides 24-hour nursing service which is sufficient to meet nursing needs in accordance with the patient care policies developed as provided in 405.1121(1). The policies ensure that each patient receives treatments, medications, and diet as prescribed, and rehabilitative nursing care as needed; receives proper care to prevent decubitus ulcers and deformities, and is kept comfortable, clean, well-groomed, and protected from accident, injury, and infection; and encouraged, assisted, and trained in self-care and group activities. Nursing personnel, including at least one registered nurse on the day tour of duty 7 days a week, licensed practical (vocational) nurses, nurse aides, orderlies, and ward clerks, are assigned duties consistent with their education and experience, and based on the characteristics of the patient load and the kinds of nursing skills needed to provide care to the patients. Weekly time schedules are maintained and indicate the number and classification of nursing personnel, including relief personnel, who worked on each unit for each tour of duty.	(c) Standard 1. Twenty-four-hour nursing service requires that the number and type of personnel are sufficient to meet the total needs of the patients in terms of: a. Maintaining physiological functions, i.e., fluid balance, elimination, electrolyte status, respiratory status, functional capacity of musculature, neurologic status and nutritional status; b. Assisting patients to learn to live with their condition and to care for themselves; c. Giving assistance in maintaining optimal physical and psychological functioning; d. Encouraging out-of-bed activities as permitted; e. Protecting from accident and injury by appropriate safety measures; f. Assuring that the routine, special, and emergency needs of all patients are met at all times, including the need for safety in event of fire or other disaster; and g. Promptly responding to patient calls. 2. The adequacy of the staffing pattern is dependent upon: a. Purposes and objectives of the facility;	(c) Standard In order to determine the adequacy of the nursing staff, the surveyor: 1. Visits patient care areas, observes the positioning of patients, interactions of personnel and patients, response to patient calls, etc.; 2. Talks with patients and personnel concerning care; 3. Compares the patient care plan with personnel assignment sheets, reads medical record to ascertain that the patient is receiving prescribed therapy and that pertinent observations and patient responses are being recorded, including intake and output when appropriate; 4. Checks time sheets to verify consistency of staffing pattern for each tour of duty; 5. Reviews job descriptions of each classification of nursing personnel to see that their duties are consistent with functions of nursing services; 6. Ascertains what non-nursing functions nursing personnel are performing, i.e., interview staff, read job descriptions, check assignment sheets; 7. Checks the staffing schedule for double shifts, days worked between days off to be sure that the practice of double shifts and lengthy span of days on duty is not consistent but used only for unusual situations. 8. Verifies that a registered nurse is on duty 7 days a week during the day tour of duty.

b. Non-nursing functions performed by nursing service staff;

c. Intensity of illness, the nursing needs, and the degree of dependence of the patients;

d. Physical layout of the facility; and

e. Level of preparation and the turnover rate of the staff.

STANDARD	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
(d) Standard: Patient care plan. In coordination with the other patient care services to be provided, a written patient care plan for each patient is developed and maintained by the nursing service consonant with the attending physician's plan of medical care, and is implemented upon admission. The plan indicates care to be given and goals to be accomplished and which professional service is responsible for each element of care. The patient care plan is reviewed, evaluated, and updated as necessary by all professional personnel involved in the care of the patient.	(d) Standard 1. The written patient care plan is developed upon admission and coordinated by nursing service staff in cooperation with all other services. The plan of care is a working tool that provides a profile of the needs of the individual patient, identifies the role of each service in meeting these needs, and the supportive measures each service will use to complement each other in the accomplishment of the overall goal of care. 2. The nursing services component of the patient care plan is based on a written assessment (nursing history) of nursing needs of each patient. 3. Through patient care conferences or other methods, the patient care plan is reviewed and revised as necessary. Such review is noted in the medical record. 4. The facility's policies and procedures delineate the rules and responsibilities of each service in relation to the patient care plan. 5. The patient care plan is available for use by all personnel caring for the patient. 6. Relevant information from the patient care plan is made available with other information that is transmitted when the patient is transferred to another institution or referred for continuing care by other agencies upon discharge to the community. 7. When appropriate, the patient is aware of the goal of care and participates in the development and review of the plan.	(d) Standard 1. As the patient care plan is based on the assessment of patient needs, the surveyor compares the plan with the medical record to verify the following: a. There is a nursing history or written assessment of nursing needs of the patient on admission, and the written assessment is updated regularly, to ascertain progress and change. These assessments and changes are reflected in the care plan; b. Observation and recommendations of all professional services responsible for the patient's care are included in the plan; and c. The record indicates that the plan is followed and the goal of care is being met. 2. There are written policies and procedures concerning the development and implementation of the patient care plan including the frequency and method for review and revision by all services.

STANDARD	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
(e) Standard: Rehabilitative nursing care. Nursing personnel are trained in rehabilitative nursing, and the facility has an active program of rehabilitative nursing care which is an integral part of nursing service and is directed toward assisting each patient to achieve and maintain an optimal level of self care and independence. Rehabilitative nursing care services are performed daily for those patients who require such service, and are recorded routinely.	(e) Standard 1. The long range goal of rehabilitative nursing is to return the patients to their accustomed roles in the family and the community, or if return to the usual activities is not possible, the patient is assisted to maintain his maximum potential. 2. Nursing personnel routinely perform rehabilitative measures in their daily care of patients. These measures include: a. Maintaining good body alignment and proper positioning; b. Encouraging and assisting bed patients to change positions at least every 2 hours (day and night) to stimulate circulation and to prevent decubitus ulcers, contractures, and deformities; c. Making every effort to keep patients active and out of bed for reasonable periods of time, except when contraindicated by physicians' orders, and encouraging patient to achieve independence in activities of daily living by teaching self care, and ambulation activities. d. Assisting patients to adjust to their disabilities, to use their prosthetic devices, and to redirect their interests, if necessary;	(e) Standard To ensure that there is an ongoing program of rehabilitative nursing, the surveyor: 1. Reviews the patient care plan for evidence of planned rehabilitative nursing measures; 2. Observes patients in bed and in wheelchairs for proper body alignment, positioning, impaired circulation, and edema of the lower extremities; verifies adherence to a planned turning schedule for those patients who are confined to bed; 3. Determines if there is a bowel and bladder retraining program for incontinent patients and if it is being followed; 4. Checks the response of the patient to the rehabilitative nursing care by reviewing notes in the medical record; 5. Verifies that training and skills of rehabilitative nursing are included in the orientation and ongoing staff development program; physical therapists also participate in this program; and 6. Checks to see that all patients who are medically able, are dressed and out of bed.

e. Assisting patients to carry out prescribed therapy exercises between visits of the therapists; and

f. Assisting patients with their routine range of motion exercises.

3. Through the patient care plan, the goals of rehabilitative nursing are reinforced in the activities program, therapy services, etc.

4. Rehabilitative nursing techniques are included in the orientation program and the ongoing staff development program 405.1121(h).

STANDARD	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
(f) Standard: Supervision of patient nutrition. Nursing personnel are aware of the nutritional needs and food and fluid intake of patients and assist promptly where necessary in the feeding of patients. A procedure is established to inform the dietetic service of physicians' diet orders and of patients' dietetic problems. Food and fluid intake of patients is observed, and deviations from normal are recorded and reported to the charge nurse and the physician.	(f) Standard 1. Nursing personnel ensure that patients are served diets as prescribed. 2. Documentation of food preferences and eating habits is maintained and incorporated in the patient care plan. 3. Patients who need help in eating are promptly assisted upon being served. The need for such assistance is noted in the patient care plan. 4. Adaptive self-help devices are provided to contribute to the patient's independence in eating. 5. The director of nursing service or the charge nurse coordinates the resolution of patients' nutritional problems observed by nursing personnel, and periodically reviews diet orders with the dietetic service supervisor and/or the dietitian. 6. Food and fluid intake are observed and deviations from normal patterns are noted in the medical record. 7. There is a written procedure for the transmission of diet orders and patient requests to the dietetic service.	(f) Standard To verify that the nursing personnel are aware of the dietary needs of each patient, the surveyor: 1. Checks the patient care plan to see that the dietary needs are identified; 2. Reviews the medical record and checks the meals served to verify that the diet is given as prescribed, dietary intake is recorded as appropriate, and action is taken when problems arise; and 3. Ascertains that self-help devices are available and used and patients who require assistance in eating are promptly helped.

STANDARD

(g) Standard: Administration of drugs. Drugs and biologicals are administered only by physicians, licensed nursing personnel, or by other personnel who have completed a State-approved training program in medication administration. Procedures are established by the pharmaceutical services committee (see § 405.1127(d)) to ensure that drugs to be administered are checked against physicians' orders, that the patient is identified prior to administration of a drug, and that each patient has an individual medication record and that the dose of drug administered to that patient is properly recorded therein by the person who administered the drug. Drugs and biologicals are administered as soon as possible after doses are prepared, and are administered by the same person who prepared the doses for administration, except under single unit dose package distribution systems. (See § 405.1101(h)).

INTERPRETIVE GUIDELINES

(g) Standard

The proper administration of medications is essential to safeguard patients. The intent of permitting individuals who have completed a State-approved training program in medication administration is to allow the licensed nurses more time for patient care assessment, but at the same time provide assurance that drugs and biologicals are administered by individuals who are sufficiently trained so as not to jeopardize the health and safety of the patients.

1. The facility's records show that all personnel whose assignments include administration of medication have successfully completed a State-approved program, and have had additional orientation to the facility policies and procedures.

2. Registered nurses and licensed practical (vocational) nurses are deemed to meet the requirement for completion of a State-approved program in medication administration.

3. Drugs are administered and monitored on an individual basis, and records are adequately maintained. To improve communications, written procedures are posted.

4. The charge nurse provides ongoing supervision of personnel administering medications that includes:

   a. Regular observation of performance in actual preparation and administration; and

   b. Review of medication record for accuracy and conformance with orders.

SURVEY PROCEDURES

(g) Standard

1. To ascertain that there is an effective method for the administration of drugs, the surveyor:

   a. Checks to see if there are policies and procedures, approved by the pharmaceutical services committee, covering the administration of drugs, stop orders, etc., and that they are being followed;

   b. Reviews a sample of medication cards or the equivalent to see that they conform with the physician's order and that the order is current, drug and dosage are correct, and are administered as directed.

   c. Examines the minutes of the pharmacy committee to verify that problems in administration of drugs are being reviewed and corrective action taken;

   d. Observes preparation of drugs for administration to verify that the procedures are being followed.

   e. Verifies that if the persons authorized by facility policy to administer drugs are not licensed, there is evidence that such unlicensed personnel have completed a State approved course on administration of drugs and function under supervision of a licensed nurse; and

   f. Reviews reports of medication errors and notes their nature and frequency and corrective action taken.

2. The surveyor discusses with the director of nurses and the charge nurse their method of providing supervision and through questioning personnel who administer medications and review of appropriate documents verifies that the supervision is, in fact, being provided.

5. Written procedures for the administration of drugs and biologicals should include the following instructions:

   a. Recording in the patient's record:

      (1) method of administration;
      (2) name and dosage of drug;
      (3) site of injection (if applicable);
      (4) medication errors, adverse reaction and corrective action taken; and
      (5) name or initials of persons administering the drug or biological.

   b. Recording and reporting to the prescribing physician when prescribed drugs are not given or are refused; and

   c. Reporting immediately to the attending physician medication errors and adverse drug reactions.

6. A list of approved drug abbreviations and/or names is made available to appropriate personnel in the facility.

7. Drugs brought to a facility by the patient should be used only when in compliance with policies established by the pharmaceutical services committee. If such drugs are permitted, they are positively identified as to name and strength, stored in accordance with 405.1124(i), and administered only upon the written orders of the attending physician.

8. Self-administration of drugs is permitted only upon written order of the attending physician.

9. A system of patient identification is established and implemented to assure that drugs prescribed for one patient are not administered to another.

10. Current reference materials on the use of drugs are readily available to each nursing unit.

STANDARD	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
(h) Standard: Conformance with physicians' drug orders. Drugs are administered in accordance with written orders of the attending physician. Drugs not specifically limited as to time or number of doses when ordered are controlled by automatic stop orders or other methods in accordance with written policies. Physicians verbal orders for drugs are given only to a licensed nurse, pharmacist, or physician and are immediately recorded and signed by the person receiving the order. (Verbal orders for Schedule II drugs are permitted only in the case of a bona fide emergency situation.) Such orders are countersigned by the attending physician within 48 hours. The attending physician is notified of an automatic stop order prior to the last dose so that he may decide if the administration of the drug or biological is to be continued or altered.	(h) Standard 1. Drugs and biologicals are administered as ordered by the physician, with emphasis placed on administering drugs at the prescribed times. 2. Drugs for outpatient use are released to patients upon discharge only after labeling for outpatient use by the pharmacist, and only on written authorization by the attending physician. A notation of drugs released to patients upon discharge is entered in the medical record. 3. Stop order policies or other methods that assure that patients do not receive drugs or biologicals beyond a period of time that they are medically necessary must be established by the Pharmaceutical Services Committee. 4. Verbal orders (e.g., telephone orders) are countersigned or confirmed in writing by the attending physician within 48 hours.	(h) Standard To verify that the drug regimen complies with the physician's order, the surveyor: 1. Reads the policy for physicians' orders and checks the medical records for implementation of the policy; 2. Compares medication cards or the equivalent and the medical record to ensure that they concur with physician's orders; 3. Checks verbal orders to verify that they are taken only by licensed personnel and are correctly countersigned; and 4. Reviews the stop order policy and verifies that it is being followed.

STANDARD	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
(i) Standard: Storage of drugs and biologicals. Procedures for storing and disposing of drugs and biologicals are established by the pharmaceutical services committee. In accordance with State and Federal laws, all drugs and biologicals, are stored in locked compartments under proper temperature controls and only authorized personnel have access to the keys. Separately locked, permanently affixed compartments are provided for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1970 and other drugs subject to abuse, except under single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. An emergency medication kit approved by the pharmaceutical services committee is kept readily available.	(i) Standard Procedures ensure that: 1. Drugs and biologicals are stored in the containers in which they are received. Transfer between containers is performed only by the pharmacist. 2. Drug containers with illegible, incomplete, makeshift, damaged, worn, soiled, or missing labels are returned to the dispensing pharmacist for proper labeling. 3. No discontinued, outdated, or deteriorated drugs or biologicals are available for use in the facility. Such drugs are disposed of in compliance with Federal, State, and local laws. 4. Drugs for external use, as well as poisons, are kept separate from other medications. 5. Antiseptics, disinfectants, and germicides used in patient care, have legible, distinctive labels that identify the content and include instructions for use. 6. Compartments containing drugs and biologicals are locked when not in use, and trays or carts used to transport drugs and biologicals are not left unattended. 7. Compartments in the context of these regulations includes but is not limited to drawers, cabinets, rooms, refrigerators, carts, and boxes. 8. "Separately locked" means that the key to the separately locked Schedule II drugs is not the same key that is used to gain access to the non-Schedule II drugs. The key to the Schedule II drug is restricted to fewer personnel than the key to the non-Schedule II drugs.	(i) Standard Drugs and biologicals must be properly safeguarded. The surveyor: 1. Reviews the minutes of the pharmaceutical services committee for their recommendations for procedures for storing and disposing of drugs and biologicals and for the approval of contents of the emergency medication kit; 2. Inspects the drug storage areas to verify that they are properly controlled; 3. Questions the staff to determine who has access to the keys and verifies through observation; 4. Checks the emergency medication kit to see if it contains the recommended medications with expiration date and check to see that it is readily available; 5. Reviews the pharmacist's quarterly report to see if recommendations to nursing services have been acted upon; 6. Checks to see that drugs and biologicals are current, not outdated, properly refrigerated, if necessary, and that external medications are separated from internal medications; and 7. Reviews drug records, checks random sample of narcotics on hand with the accounting records.

STANDARD

405.1125 Condition of participation--dietetic services.

The skilled nursing facility provides a hygienic dietetic service that meets the daily nutritional needs of patients, ensures that special dietary needs are met, and provides palatable and attractive meals. A facility that has a contract with an outside food management company may be found to be in compliance with this conditions provided the facility and/or company meets the standards listed herein.

(a) Standard: Staffing. Overall supervisory responsibility for the dietetic service is assigned to a full-time qualified dietetic service supervisor. If the dietetic service supervisor is not a qualified dietitian he functions with frequent, regularly scheduled consultation from a person so qualified. (See § 405.1121(i)). In addition, the facility employs sufficient supportive personnel competent to carry out the functions of the dietetic service. Food service personnel are on duty daily over a period of 12 or more hours. If consultant dietetic services are used, the consultant's visits are at appropriate times, and of sufficient duration and frequency to provide continuing liaison with medical and nursing staffs, advice to the administrator, patient counseling, guidance to the supervisor and staff of the dietetic service approval of all menus, and participation in development or revision of dietetic policies and procedures and in planning and conducting inservice education programs (see § 405.1121(h)).

INTERPRETIVE GUIDELINES

405.1125 Dietetic services

Although a skilled nursing facility may contract with an outside food management company for dietetic services, this does not relieve the facility of its responsibility of assuring that the contractor meets all the standards of this condition and standards (g) and (h) of condition 405.1134. How these standards are to be met should be formalized through a written agreement between the skilled nursing facility and the contractor. It is the facility's responsibility to see that an adequate supply of staples is maintained on the premises along with a plan to meet potential emergencies that could delay or interrupt contracted food services or supplies.

(a) Standard

1. The dietetic service supervisor has responsibility, with guidance from the qualified dietitian, when applicable, for:

   a. Orientation, work assignments, supervision of work and food handling techniques of all dietetic service personnel and for ensuring that staff members who exhibit signs of a communicable disease are not on duty.

   b. Participation in regularly scheduled conferences with the administrator and department heads and in the development of dietetic policies, procedures, and staff development programs;

   c. Menu planning, recommending supplies to be purchased, maintaining essential records of costs, menus, personnel, etc.

SURVEY PROCEDURES

405.1125 - Dietetic services.

(a) Standard

1. The qualifications of the dietetic service supervisor and/or dietitian are checked to verify that they meet the definition as stated in 405.1101(e) and/or (f).

2. A dietetic service supervisor who is enrolled in a course that is scheduled to be completed during the term of the time-limited agreement may be considered qualified to supervise the dietetic service if upon completion of the course, the employee meets the qualifications in 405.1101(e). After January 31, 1975, the employee must have completed the course to fulfill the requirement.

3. If the dietetic service supervisor is not a qualified dietitian as set forth in 405.1101(f), the surveyor determines if the facility has made provision for regular consultation from a person so qualified. The adequacy of the consultation is evaluated in terms of the overall operation of the service, and with particular attention to evidence of the consultants participation in:

2. If the dietitic service supervisor also has responsibility for cooking, ample time is provided for the management of the service. If cooking responsibilities do not permit adequate time for management of the service, the cook cannot be the dietetic service supervisor.

3. The dietitian consultant (405.1101(f)) has responsibility for:

   a. Scheduling visits to assure that the professional dietetic service needs of the facility are met. Adequate time should be allowed to observe the preparation and serving of food at meal time;

   b. Scheduling consultation visits so that they are not limited to evenings and weekends only;

   c. Providing the services listed in 405.1125(a) and (c) for a recommended duration of four or more continuous hours per visit;

   d. Assisting the dietetic supervisor with items 1b and 1c of these guidelines;

   e. Integrating the dietetic aspects of patient care through communication and the sharing of specialized information with the medical and nursing staff and contributing pertinent information to patient care plans;

   f. Providing the administrator with oral and written reports or recommendations for the dietetic service and of plans for their implementation;

   a. Staff development program 405.1121(h);

   b. Development of policies and procedures 405.1122(a);

   c. Approval of menus;

   d. Patient counseling; and

   e. Liaison with other services, e.g., nursing.

4. Through a review of the time books, assignment sheets, observations of meal service and interviews with dietetic service personnel, the surveyor evaluates the adequacy of the staff in terms of number and capability.

5. If the facility is under contract with an outside food management company, the surveyor examines the contract to ensure that the contractor agrees to meet the requirements of these standards.

g. Counseling patients and/or their families concerning regular and/or therapeutic diets and interpreting their needs for such diets;

h. Reviewing and approving all regular and therapeutic menus;

i. Assisting in planning and budgeting for dietetic services;

j. Participating with the assistance of the dietetic service supervisor in developing written plans for inservice training and in conducting such services for dietetic services employees at least monthly; and

k. Maintaining a record of dates, time, and length of visits and functions performed as well as making entry in the patient's records.

4. The supportive dietetic staff should be sufficient in number and competency in order that:

   a. The functions of the dietetic service are carried out and needs of the patients are met; and

   b. Personnel tours of duty cover a 12 hour span of time.

5. Dietetic support staff are trained to perform assigned duties and are allowed sufficient time to participate in regularly scheduled inservice education.

STANDARD	INTERPRETIVE GUIDELINES	SURVEY PROCEDURE
(b) Standard: Menus and nutritional adequacy. Menus are planned and followed to meet nutritional needs of patients in accordance with physicians' orders and, to the extent medically possible, in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences.	(b) Standard 1. Menus are planned and followed to meet nutritional needs in accordance with the National Research Council recommended dietary allowances. 2. Menus for regular and routine therapeutic diets are planned at least two weeks in advance. 3. The current week's menu is posted in the dietetic department. 4. Menus provide sufficient variety of foods served in adequate amounts at each meal to satisfy recommended dietary allowances. 5. A different menu is followed for each day of the week; if cycle menu is used, the cycle must cover a minimum of 3 weeks. 6. Menus are adjusted for seasonal changes. 7. Dated records of menus, including substitutes, are retained for 30 days.	(b) Standard 1. The current menu and previous menus are carefully checked to determine if they meet the recommended dietary allowances, that includes: a. Milk - two or more cups; b. Meat group - two or more servings: Beef, veal, pork, lamb, poultry, fish, eggs, occasionally dry beans, nuts, or dry peas may be served as alternates; c. Vegetable and fruit group - four or more servings: A citrus fruit or other fruit and vegetable important for vitamin C; A dark green or deep yellow vegetable for vitamin A, at least every other day; Other vegetables and fruits including potatoes; d. Bread and cereal group - four or more servings of whole grain enriched or restored; e. Other foods to complete meals and provide snacks. 2. The surveyor observes the serving of a meal to determine if the items being served are the same as those shown on the posted menu and if the amounts served are in the same quantities as indicated by the daily food guide. Visits patients at meal time to observe food acceptance. 3. Menus are reviewed to ascertain if substitutions were of equivalent food value. 4. The surveyor checks to see that substitutions are recorded on the menu and that the menus are planned at least two weeks in advance.

STANDARD	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
(c) Standard: Therapeutic diets. Therapeutic diets are prescribed by the attending physician. Therapeutic menus are planned in writing, and prepared and served as ordered, with supervision or consultation from the dietitian and advice from the physician whenever necessary. A current therapeutic diet manual approved by the dietitian is readily available to attending physicians and nursing and dietetic service personnel.	(c) Standard 1. Therapeutic diet orders prescribed by attending physicians are reviewed regularly along with other orders. 2. Routine therapeutic menus may be planned by the dietetic service supervisor and approved by the dietitian; however, unusual or complex therapeutic diets are planned in writing by the dietitian. 3. An identification system is established to ensure that each patient receives his diet as ordered. 4. The dietitian records in the patient's medical record significant information relating to the patient's response to his/her therapeutic diet.	(c) Standard 1. The surveyor reviews the processing of a therapeutic diet from the time the prescription is written through diet counseling upon discharge. The procedures include: a. Method for transmission of the order from nursing to dietary service; b. Planning of the diet by dietitian; c. Patient identification system; d. Regular review of diet; and e. Instruction of patient and family before discharge. 2. The surveyor observes preparation and serving to ensure that the diets served are in conformance with the physician's order.

STANDARD	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
(d) Standard: Frequency of meals. At least three meals or their equivalent are served daily, at regular hours with not more than a 14-hour span between substantial evening meal and breakfast. To the extent medically possible, bedtime nourishments are offered routinely to all patients.	(d) Standard 1. Bedtime snacks of nourishing quality are offered routinely to all patients not on diets prohibiting bedtime nourishment. Snacks of nourishing quality are those which provide substantive protein and/or nutrients in addition to carbohydrates and calories, i.e., milk and milk drinks, fruit juice, sometimes with cookies or graham crackers. 2. A substantial evening meal is an offering of three or more menu items at one time, one of which includes a high quality protein such as meat, fish, eggs, or cheese, The meal represents no less than 20% of the day's total nutritional requirements.	(d) Standard Through the review of the schedule of meals and menus and interviews with patients, the surveyor ascertains that: 1. Meals are served at regular hours and the space between the evening meal and breakfast does not exceed 14 hours. 2. If a nourishing snack is provided at bedtime, the surveyor may consider a slightly lower span as meeting the intent of this standard.
(e) Standard: Preparation and service of food. Foods are prepared by methods that conserve nutritive value, flavor, and appearance, and are attractively served at the proper temperatures and in a form to meet individual needs. If a patient refuses food served, appropriate substitutes of similar nutritive value are offered.	(e) Standard 1. A file of recipes, adjusted to appropriate yield, is maintained. 2. Food is cut, chopped, or ground to meet individual needs. 3. Effective equipment is provided and procedures are established to maintain food at proper temperature during serving. 4. Table service is provided for all who so desire, including wheel chair patients. 5. Trays provided bedfast patients should rest on firm supports, such as overbed tables. Sturdy tray stands of proper height are provided ambulatory patients.	(e) Standard Through conversations with patients, observation of meal service, and survey of the dietetic service, the following are noted: 1. Food is cut, chopped, or ground to meet individual needs and is attractively served; 2. A file of tested recipes is maintained; 3. If a patient refuses food, substitutes of similar nutritive value are offered; 4. Equipment is provided and procedures established to maintain food at proper temperature during serving; 5. Table service is provided for all medically able patients, and trays are served promptly; 6. Trays provided bedfast patients rest on firm supports such as overbed tables. Sturdy tray stands of proper height are provided ambulatory patients; and 7. Patients are ready for meal when served.

STANDARD	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
(f) Standard: Hygiene of staff. Dietetic service personnel are free of communicable diseases and practice hygienic food-handling techniques. In the event food service employees are assigned duties outside the dietetic service, these duties do not interfere with the sanitation, safety, or time required for dietetic work assignments. (See 405.1121(g)).	(f) Standard 1. Dietetic personnel must wear clean washable garments. Hair nets are required for personnel with long hair and caps for personnel with very short hair. 2. Personnel must keep hands and fingernails clean at all times. 3. Routine health examinations at least meet local, State, or Federal codes for dietetic personnel. Where food handler permits are required, they should be current, 405.1120(c). 4. If dietetic employees are assigned duties outside the dietetic department, these duties do not interfere with the sanitation and safety required for dietetic work assignments, such as sorting soiled laundry.	(f) Standard 1. The surveyor, in the tour of the dietetic services, observes the personnel to verify that they are following acceptable techniques, e.g., hairnets, handwashing. 2. The job descriptions and work assignments are reviewed and personnel questioned to determine if they perform duties outside the dietetic services and if so, assess these functions in terms of staffing adequacy and safe practice. 3. The surveyor verifies that the health requirements for food service personnel, 405.1120(c) and 405.1121(g), are being followed.

STANDARD	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
(g) Standard: Sanitary conditions. Food is procured from sources approved or considered satisfactory by Federal, State, or local authorities, and stored, prepared, distributed, and served under sanitary conditions. Waste is disposed of properly. Written reports of inspections by State and local health authorities are on file at the facility, with notation made of action taken by the facility to comply with any recommendations.	(g) Standard 1. Food is stored, prepared, and transported at appropriate temperatures and by methods to prevent contamination. Potentially hazardous food, i.e., any perishable food which consists of milk or milk products, meats, poultry, fish, shellfish, or other ingredients capable of supporting rapid growth of harmful microorganisms, should be maintained at safe temperatures: (45° F or below or 140° F or above) from preparation to serving. 2. Procedures and maintenance schedules for dishwashing, cleaning equipment, and work areas are posted and followed consistently. 3. Waste which is not disposed by mechanical means is kept in leak-proof nonabsorbent containers with close-fitting covers, and is disposed of daily. Nondisposable containers are cleaned upon disposal of contents.	(g) Standard 1. The surveyor tours the kitchen facilities, storage areas, etc. and determines if food is stored, prepared, and transported at appropriate temperatures and in a sanitary manner, as stated in the guideline for 405.1125(g). 2. Reports of inspections by health authorities are reviewed and if deficiencies are cited, the steps taken to correct them should be noted.

STANDARD

405.1126 Condition of participation--specialized rehabilitative services.

In addition to rehabilitative nursing (405.1124(c)), the skilled nursing facility provides, or arranges for, under written agreement, specialized rehabilitative services by qualified personnel (i.e., physical therapy, speech pathology and audiology, and occupational therapy) as needed by patients to improve and maintain functioning. These services are provided upon the written order of the patient's attending physician. Safe and adequate space and equipment are available, commensurate with the services offered. If the facility does not offer such services directly, it does not admit nor retain patients in need of this care unless provision is made for such services under arrangement with qualified outside resources under which the facility assumes professional ~~and financial~~ responsibilities for the services rendered. (See 405.1121(i).)

(a) Standard: Organization and staffing. Specialized rehabilitative services are provided, in accordance with accepted professional practices, by qualified therapists or by qualified assistants or other supportive personnel under the supervision of qualified therapists. Other rehabilitative services also may be provided, but must be in a facility where all rehabilitative services are provided through an organized rehabilitative service under the supervision of a physician qualified in physical medicine who determines the goals and limitations of these services and assigns duties appropriate to the training and experience of those

INTERPRETIVE GUIDELINES

405.1126 Specialized Rehabilitative Services.

Space, facilities, and equipment for the service are conducive to the safe and effective care of the patient.

a. Each rehabilitation service area is easily accessible to patients requiring such services. Adequate space shall be provided for the reception, examination, diagnostic study, and treatment of patients, as well as for the related clerical work, conferences, and when applicable, teaching sessions.

b. Equipment is structurally sound and routinely calibrated; principles of electrical safety are observed.

c. Equipment is periodically inspected and maintained.

(a) Standard

1. There is an organizational structure designed for the effective implementation of the objectives of the service.

2. When the facility provides rehabilitative services, they are identified in a written organizational plan with a definition of the responsibility, authority, and relationship of all positions within each discipline and the relationship of these services to the facility.

405.1126 - Specialized rehabilitative services.

Any of these services contracted with an outside agency is covered by a written agreement and signed by the administrator and therapist. The surveyor examines the agreement to ascertain that reference is made to the:

1. Delineated responsibilities of both parties;

2. Required qualifications of the therapist;

3. Responsibilities for supplies, equipment, and maintenance;

4. Time limit of contract; and

5. Stated amount and method of remuneration.

(a) Standard

1. The facility's administrative and patient care policies are reviewed to ascertain that there is an effective organizational structure which facilitates the achievement of service objectives. At least a brief statement is contained in the policy about the following areas:

   a. Whether the services are provided directly or through written agreement;

   b. Objectives are identified with specified outcome;

   c. Personnel specifications which allow for employing qualified persons to provide and/or supervise these services;

STANDARD	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
providing such services. Written administrative and patient care policies and procedures are developed for rehabilitative services by appropriate therapists and representatives of the medical, administrative, and nursing staffs.	3. Each service is staffed by an adequate number of qualified professional and supportive personnel, under the direction of a qualified professional who meets appropriate educational, experience, and legal requirements of 405.1101(m), (q), (t). 4. A qualified professional (s 405.1101m,q,t) from the specific discipline providing the service is on the premises to: a. Evaluate each patient and initiate the treatment; b. Re-evaluate the patient as change of condition indicates but at least every 30 days; and c. Supervise the operation of the service on a regular basis to ensure an acceptable level of performance from the assistants and supportive staff. 5. The written policies and procedures list the types of services available, and cover such subjects as: a. Consultation; b. Responsibilities of attending physicians; c. Delineation of the team approach when used; d. Priorities in the use of available services, if applicable; e. An outline of an effective follow-up program; and f. Participation in inservice educational programs for the entire rehabilitation service and the nursing services staff.	d. Provisions for coordinating these services with other services identified in the patient care plan; e. Authority delegated to carry out these responsibilities in line with the qualifications set forth; f. Reference to the responsibility of the patient's physician and other required specialized personnel for participating in the overall patient care plan; g. Appropriate channels of communication to route recommendations for service's improvements. 2. The surveyor determines if the staff has access to the policies and is aware of their content through discussion with them. 3. The surveyor verifies that the qualified professional: a. Evaluates the patient, initiates the treatment, re-evaluates the patient at least every 30 days; and b. Provides regular supervision of the operation of the service and performance of the staff.

STANDARD	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
(b) Standard: Plan of care. Rehabilitative services are provided under a written plan of care, initiated by the attending physician and developed in consultation with appropriate therapist(s) and the nursing service. Therapy is provided only upon written orders of the attending physician. A report of the patient's progress is communicated to the attending physician within 2 weeks of the initiation of specialized rehabilitative services. The patient's progress is thereafter reviewed regularly, and the plan of rehabilitative care is reevaluated as necessary, but at least every 30 days, by the physician and the therapist(s).	(b) Standard 1. Rehabilitation services shall be initiated only upon the written request of a physician responsible for the patient's care. The request shall include the diagnosis of problems for which treatment is planned and the objectives of treatment. 2. The written plan covers treatment, objectives, rehabilitation potential, precautions, type, amount, frequency and duration of the treatment, procedures and modalities to be applied, and is coordinated with the total patient care plan (405.1124(d) and (e)).	(b) Standard 1. The plan of patient care is reviewed to: a. Evaluate the extent of participation of the therapist and others of the health team in the planning of total patient care; b. Ascertain that the written orders initiated by the attending physician, after consultation with the appropriate therapist, contain modality, duration, and frequency of treatment. 2. A review of the patient's medical record is required to document whether the written plan is being implemented appropriately. The surveyor ascertains that the medical record: a. Contains clinical data of assessment of the patient's functional ability, etc., and a record of patient's response to therapy; b. Indicates the degree of rehabilitative nursing care activities provided as well as the specific rehabilitation services; and c. Shows that the plan has been re-evaluated and updated as required.
(c) Standard : Documentation of services. The physician's orders, the plan of rehabilitative care, services rendered, evaluations of progress, and other pertinent information are recorded in the patient's medical record, and are dated and signed by the physician ordering the service and the person who provided the service.	(c) Standard The individual providing the service notes in the medical record the patient's status including: 1. Baseline clinical data from initial evaluation, i.e., tests and measurements of strength, balance, endurance, range of motion, electrical myoneural responses, etc. 2. Objectives of treatment;	(c) Standard 1. The surveyor makes an additional review of the patient's record and other reports that are required, for evidence that: a. Reports and records are complete; b. All reports are signed by the person providing therapy; and

STANDARD	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
	3. Treatment procedures, showing frequency and dates of treatment; 4. Authorization for delegation of treatment procedures, if applicable; 5. Review and/or revision of care plan, if applicable; 6. Clinical data documenting the patient's response to treatment; 7. Discharge status, including plans for continued care with instructions given to the patient and his family, if applicable.	c. Dates are indicated on all reports as to when therapy was performed and when the results were reported to the attending physician (within 2 weeks).
(d) Standard: Qualifying to provide outpatient physical therapy services. If the facility provides outpatient physical therapy services, it meets the applicable health and safety regulations pertaining to such services as are included in Subpart Q of this part. (See 405.1719; 405.1720; 405.1722(a) and (b)(1), (2), (3)(i), (4), (5), (6), (7), and (8); and 405.1725.))	(d) Standard 1. The facility must comply with the conditions of participation for rehabilitation agencies, clinics, public health agencies as providers of outpatient physical therapy and speech pathology/ audiology.	(d) Standard The conditions of participation for Skilled Nursing Facilities exceed or are the equivalent of the reference requirements in this standard, except for the following: 405.1720(b) and (d) and 405.1725(c)(4)(iii)(a-c). Therefore the surveyor need only complete these portions of the survey report form for subpart Q. (SSA-1893).

STANDARD

405.1127 Condition of participation--pharmaceutical services.

The skilled nursing facility provides appropriate methods and procedures for the dispensing and administering of drugs and biologicals. Whether drugs and biologicals are obtained from community or institutional pharmacists or stocked by the facility, the facility is responsible for providing such drugs and biologicals for its patients, insofar as they are covered under the programs, and for ensuring that pharmaceutical services are provided in accordance with accepted professional principles and appropriate Federal, State, and local laws. (See § 405.1124(g), (h), and (i).)

(a) Standard: Supervision of services. The pharmaceutical services are under the general supervision of a qualified pharmacist who is responsible to the administrative staff for developing, coordinating, and supervising all pharmaceutical services. The pharmacist (if not a full-time employee) devotes a sufficient number of hours, based upon the needs of the facility, during regularly scheduled visits to carry out these responsibilities. The pharmacist reviews the drug regimen of each patient at least monthly, and reports any irregularities to the medical director and administrator. The pharmacist submits a written report at least quarterly to the pharmaceutical services committee on the status of the facility's pharmaceutical service and staff performance.

INTERPRETIVE GUIDELINES

405.1127 Pharmaceutical services

(a) Standard

1. The pharmacist is responsible for determining that the policies and procedures set forth in § 405.1124(g), (h), and (i) are followed.

2. Supervision in the context of pharmaceutical services does not require on the premises supervision by the pharmacist as denoted by § 405.1101(u), but is fulfilled through regularly scheduled visits.

3. The frequency of the regularly scheduled visits must be determined by the needs of the facility.

[illegible]

405.1127 - Pharmaceutical services

(a) Standard

Emphasis is placed on the provision of the service and not on its method of delivery. Whether the facility utilizes the unit dose, individual prescription, or the floor stock system, or a combination of these systems, or whether the facility maintains its own pharmacy or provides the service through arrangements with a community or institutional pharmacy, the emphasis is placed on the patient receiving the service in a safe and efficacious manner. Therefore, the total service is assessed.

STANDARD

INTERPRETIVE GUIDELINES

4. Documentation of the review of the drug regimen of each patient is accomplished in the following manner. If the pharmacist determines that there are no irregularities in the patient's drug regimen, he must note in the patient's chart that he has reviewed that drug regimen, found no irregularities, and must sign and date this notation. If this pharmacist determines that there are irregularities, he must prepare a drug regimen review summary which includes as a minimum, the patient's diagnosis(es), the drug regimen, any pertinent laboratory findings, any dietary considerations, and his recommendations for improving the drug therapy of the patient.

5. The review of the drug regimen by the pharmacist may be performed in the pharmacy that serves the facility; however, documentation of these reviews is maintained in the facility.

6. Potential problems in a patient's drug regimen are reported by submitting the drug regimen summary to the medical director and the administrator.

7. Inappropriate drug administration findings are reported to the director of nursing and the administrator.

8. Only the pharmacist, or authorized pharmacy personnel under the direct supervision of the pharmacist, compounds or dispenses drugs and biologicals, prepares labels, or makes labeling changes. When the pharmacist is not available, drugs are removed from the pharmacy (drug storage area) only by a designated licensed nurse or a physician and only in amounts sufficient for immediate therapeutic needs. Records are maintained of such withdrawals.

SURVEY PROCEDURES

1. The surveyor reviews the job description and the written agreement to see that the responsibilities of the pharmacist are clearly delineated.

2. The surveyor determines that:

   a. Policies and procedures are being followed;

   b. Drugs and biologicals are properly stored; and

   c. Pharmaceutical services are provided by the pharmacist.

3. If the pharmacist (405.1101(p)) is not a full-time employee, the facility has a consultant pharmacist. The surveyor should verify that the pharmacist visits regularly and devotes sufficient time to meet the needs of the facility in terms of:

   a. Monthly review of the drug regimen of each patient;

   b. Reports of status of pharmaceutical services and staff performance; and

   c. Overall efficiency of the service.

STANDARD	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
(b) Standard: Control and accountability. The pharmaceutical service has procedures for control and accountability of all drugs and biologicals throughout the facility. Only approved drugs and biologicals are used in the facility, and are dispensed in compliance with Federal and State laws. Records of receipt and disposition of all controlled drugs are maintained in sufficient detail to enable an accurate reconciliation. The pharmacist determines that drug records are in order and that an account of all controlled drugs is maintained and reconciled.	(b) Standard 1. The Pharmaceutical Services Committee establishes procedures that prevent unauthorized drug usage and distribution. These procedures provide for an accounting of the receipt and disposition of all drugs, and in particular, drugs subject to the Comprehensive Drug Abuse Prevention and Control Act of 1970. 2. The pharmacist must determine if records are periodically updated to accurately reflect the number of controlled drugs administered and the number in stock; this ensures a record of controlled drugs which would disclose unauthorized use. If a discrepancy is discovered, the pharmacist should immediately notify the director of nursing and the administrator, and assist them in implementing a control procedure. 3. The individual medication record (see 405.1124(g)) can serve as a record of the receipt and disposition of all controlled drugs when the unit dose and individual prescription drug distribution systems are used. However, if a floor stock system is used, a separate record will have to be maintained for the receipt and disposition of these drugs.	(b) Standard 1. The policies and procedures are reviewed to see that they include: a. Receipt and disposition of drugs and biologicals; b. Methods of reconciliation, such as control and distribution; and c. Reporting discrepancies and follow-up actions. 2. The pharmacist, administrator, and director of nurses are interviewed to determine their understanding of the pharmaceutical services and the degree of cooperation that exists.

STANDARD	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
(c) Standard: Labeling of drugs and biologicals. The labeling of drugs and biologicals is based on currently accepted professional principles, and includes the appropriate accessory and cautionary instructions, as well as the expiration date when applicable.	(c) Standard 1. The labeling requirements for each distribution system are as follows: a. Each patient's individual drug container bears his full name, the prescribing physician's name, and the name, strength, and quantity of the drug dispensed. Appropriate accessory and cautionary statements are included, as well as the expiration date when applicable. b. Each floor stock drug container bears the name and strength of the drug, lot and control number, expiration date when applicable, and any other appropriate accessory or cautionary statements. c. Each single unit package bears the name and strength of the drug and the lot or control number, and is clearly identified with the patient's full name and the prescribing physician's name. Appropriate accessory and cautionary statements are included, as well as the expiration date, if applicable. The name of the patient and the physician does not have to be on the label of the package, but they must be identified with the package in such a manner as to assure that the drug is administered to the right patient. 2. The labeling requirements of over-the-counter drugs (drugs which do not legally require a prescription) are based on criteria established by the Pharmaceutical Services Committee.	(c) Standard The surveyor checks the labels of the individual patient's drug containers and floor stock drug containers to verify that they conform with the guidelines 405.1127(c).

STANDARD	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
(d) Standard: Pharmaceutical services committee. A pharmaceutical services committee (or its equivalent) develops written policies and procedures for safe and effective drug therapy, distribution, control, and use. The committee is comprised of at least the pharmacist, the director of nursing services, the administrator, and one physician. The committee oversees pharmaceutical service in the facility, makes recommendations for improvement, and monitors the service to ensure its accuracy and adequacy. The committee meets at least quarterly and documents its activities, findings, and recommendations.	(d) Standard 1. The pharmaceutical services committee should: a. Receive and appropriately act on the pharmacists's written report (See 405.1127(a)); b. Establish stop-order policies or other methods to assure the appropriateness of continued drug therapy. (See 405.1124(h)); c. Determine the contents of the emergency medication kit (See 405.1124(i)). The contents of the emergency medication kit must be in compliance with State laws and regulations; d. Establish the qualifications for non-licensed nursing personnel permitted to administer medications, e.g., the training requirements, in addition to the State Approved Program and the type of supervision to be provided (405.1124(g)); e. Develop a list of abbreviations and chemical symbols that are approved for use in ordering medications in the facility; f. Develop policies and procedures for the safe procurement, storage, distribution, and use of drugs and biologicals (See 405.1124(i));	(d) Standard 1. The surveyor reviews the composition, function and frequency of meetings of the pharmaceutical services committee. 2. The minutes of the committee should include date of the meeting, members present, duration of the meeting, topics discussed and actions taken. 3. Through review of the minutes, observation of the functioning of the pharmaceutical and nursing services, the surveyor determines if the committee is fulfilling its functions as stated by the facility and that the recommendations of the committee are implemented.

g. Determine which personnel will be authorized to have access to the keys to the drug storage areas (See 405.1124(i));

h. Determine the labeling requirements for over-the-counter drugs;

i. Establish policies for the use of drugs brought to the facility by the patient; and

j. Determine what reference materials should be available to each nursing unit.

STANDARD	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
405.1128 Condition of participation--laboratory and radiologic services.	405.1128 Laboratory and radiologic services	405.1128 - Laboratory and radiologic services.
The skilled nursing facility has provision for promptly obtaining required laboratory, X-ray, and other diagnostic services.		
(a) Standard: Provision for services. If the facility provides its own laboratory and X-ray services, these meet the applicable conditions established for certification of hospitals that are contained in §§ 405.1028 and 405.1029 respectively. If the facility itself does not provide such services, arrangements are made for obtaining these services from a physician's office, a participating hospital or skilled nursing facility, or a portable X-ray supplier or independent laboratory which is approved to provide these services under the program. All such services are provided only on the orders of the attending physician, who is notified promptly of the findings. The facility assists the patient, if necessary, in arranging for transportation to and from the source of service. Signed and dated reports of a clinical laboratory, X-ray, and other diagnostic services are filed with the patient's medical record.	(a) Standard The policy manual lists the source of the laboratory and radiology services available for the patient. 1. If the service is provided by another agency there is a written agreement that specifies the responsibility of the facility and outside provider. 2. If the service is provided by the facility, the survey will include the appropriate section of the Conditions of Participation for hospitals (405.1128 and/or 405.1029).	(a) Standard The surveyor first reviews the skilled nursing facility's policy to determine if it provides these services or whether they are contracted. Since it is highly probable that all laboratory and radiological services will be provided by an outside facility, the surveyor examines: 1. The facility's agreement to determine that the outside resource is a participant in the appropriate Federal program; and 2. A sampling of patient records to ascertain that the requests were initiated by the attending physician, that the examination results were made available promptly, and that all reports are dated and signed by the appropriate person, i.e., the pathologist, radiologist.

STANDARD	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
(b) Standard: Blood and blood products. Blood handling and storage facilities are safe, adequate, and properly supervised. If the facility provides for maintaining and transfusing blood and blood products, it meets the conditions established for certification of hospitals that are contained in 405.1028(j). If the facility does not provide its own facilities but does provide transfusion services alone, it meets at least the requirements of 405.1028(j)(1), (3), (4), (6), and (9).	(b) Standard The applicable sections in 405.1023(j) are: 1. The facility maintains, as a minimum, proper blood storage facilities under adequate control and supervision of a pathologist or other authorized physician. 2. When the facility depends on outside blood banks, there is an agreement governing the procurement and transfer that must be approved by the patient care policy committee, the administration, and the governing body. 3. There is provision for prompt blood typing and cross-matching and for laboratory investigation of transfusion reactions, either through the facility or by arrangements with others on a continuous basis, under the supervision of a physician. 4. Records are kept on file indicating the receipt and disposition of all blood provided to patients in the facility. 5. The review committee investigates all transfusion reactions occurring in the facility and makes recommendations to the medical staff regarding improvements in transfusion procedures.	(b) Standard: 1. Even though a skilled nursing facility may keep blood for only short periods of time, the surveyor verifies that: a. Written policies and procedures are readily available for the staff which identify a prescribed course of action for blood handling, storage, administration, and adverse reactions; and b. A storage facility is maintained at adequate temperature and that it is equipped with a recording thermometer to insure safe refrigeration (preferably with an alarm device which notifies appropriate personnel of faulty temperatures or electrical failures). 2. The surveyor reviews the medical record and/or transfusion reaction reports to verify that the policies and procedures are being followed.

STANDARD	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
405.1129 Condition of participation—dental services.	**405.1129 Dental services**	**405.1129 - Dental services.**
The skilled nursing facility has satisfactory arrangements to assist patients to obtain routine and emergency dental care (See 405.1121(i).) (The basic Hospital Insurance Program does not cover the services of a dentist in a skilled nursing facility in connection with the care, treatment, filling, removal, or replacement of teeth or structures supporting the teeth; and only certain oral surgery is included in the Supplemental Medical Insurance Program.)	The facility is responsible for maintaining good oral health and hygiene and for making arrangements for the more specialized services. Routine examinations, although not required per se by the program, are invaluable to the elderly because of their susceptibility to malfunctioning dentures and oral cancer. A healthy mouth promotes acceptance of a balanced diet and is conducive to good health.	
(a) Standard: Advisory dentist. An advisory dentist participates in the staff development program for nursing and other appropriate personnel (see 405.1121 (h)), and recommends oral hygiene policies and practices for the care of patients.	(a) Standard The advisory dentist will assist the facility to formulate dental health policies and will provide direction for inservice training to give the staff a better understanding of the dental problems that patients experience.	(a) Standard 1. The surveyor reviews the records of the staff development program to verify that the advisory dentist provides consultation in the development of the program. Oral hygiene and understanding dental problems of the elderly are included in the program. 2. The surveyor reviews the policy manual to determine if recommendations from advisory dentist are incoroporated. The administrator and staff are interviewed to determine if the recommendations are implemented.

STANDARD	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
(b) Standard: Arrangements for outside services. The facility has a cooperative agreement with a dental service, and maintains a list of dentists in the community for patients who do not have a private dentist. The facility assists the patient, if necessary, in arranging for transportation to and from the dentist's office.	(b) Standard 1. The name, address, and telephone number of the dentists available for service are readily available. 2. Assistance constitutes making the appointments and arrangements for transportation to and from the dentist's office, if necessary.	(b) Standard 1. The surveyor reviews the agreement for the provision of dental services. 2. The surveyor verifies that the facility has a list of community dentists available and that arrangements are made for patient transportation.

STANDARD	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
405.1130 Condition of participation--social services.	**405.1130 Social services**	**405.1130 - Social services.**
The skilled nursing facility has satisfactory arrangements for identifying the medically related social and emotional needs of the patient. It is not mandatory that the skilled nursing facility itself provide social services in order to participate in the program. If the facility does not provide social services, it has written procedures for referring patients in need of social services to appropriate social agencies. If social services are offered by the facility, they are provided under a clearly defined plan, by qualified persons, to assist each patient to adjust to the social and emotional aspects of his illness, treatment, and stay in the facility.	Although a facility chooses not to provide social services directly, it may designate an individual to maintain liaision with social health and community agencies. If the State licensure code requires the provision of social services, the facility must meet these standards.	The facility does not have to provide social services but it must have provisions for the identification of medically related social needs and arrangements for meeting these needs. To verify that the facility fulfills this requirement, Standards (a) and (c) must be surveyed. If the facility provides social services, all standards must be met.
(a) Standard: Social service functions. The medically related social and emotional needs of the patient are identified and services provided to meet them, either by qualified staff of the facility, or by referral, based on established procedures, to appropriate social agencies. If financial assistance is indicated, arrangements are made promptly for referral to an appropriate agency. The patient and his family or responsible person are fully informed of the patient's personal and property rights.	(a) Standard 1. The social service staff participates with other staff members in the development and formulation of the patient care plan. Social and emotional needs related to the patient's illness, response to treatment, and adjustment to care in the facility are identified and included in the patient care plan. (405.1124(d)) 2. The patient's family and home situation, information related to his medical and nursing requirements, and community resources are considered in making decisions regarding his care.	(a) Standard 1. The policy manual is reviewed to determine if it includes a statement of the range of social services to be provided. 2. The procedure manual is checked to verify that the steps to be followed in the identification of medically related social and emotional needs, including mechanism for providing the service directly or by referral, are clearly delineated. 3. A sampling of the medical records reviewed is checked for evidence of the identification of medically related social needs and that the needs were met either directly or by referral. 4. The patient care plan is examined to determine whether the medical social needs are considered.

STANDARD	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
	3. If a facility is unable to resolve a patient's problem, policies are established that direct the patient to the appropriate social agency. 4. Records are maintained of all social work functions performed, and of recommendations, if any, made by the social work consultant. 5. Contact is maintained with the family about the patient's problems and rights.	
(b) Standard: Staffing. If the facility offers social services, a member of the staff of the facility is designated as responsible for social services. If the designated person is not a qualified social worker, the facility has a written agreement with a qualified social worker or recognized social agency for consultation and assistance on a regularly scheduled basis. (See 405.1121(i).) The social service also has sufficient supportive personnel to meet patient needs. Facilities are adequate for social service personnel, easily accessible to patients and medical and other staff, and ensure privacy for interviews.	(b) Standard 1. The staff responsible for social services is sufficient in number and qualifications to meet the needs of all the facility's patients. The adequacy of personnel is determined by appropriate and timely actions, sufficient follow-ups, coordination and consultation required by other services, etc.	(b) Standard 1. The surveyor checks to see if the designated person meets the qualifications in 405.1121(s), and if not, that a person so qualified provides consultation. 2. The staff is assessed to determine if it is sufficient to render the social service program provided by the facility.

STANDARD

(c) Standard: Records and confidentiality of social data. Records of pertinent social data about personal and family problems medically related to the patient's illness and care, and of action taken to meet, his needs, are maintained in the patient's medical record. If social services are provided by an outside resource, a record is maintained of each referral to such resource. Policies and procedures are established for ensuring the confidentiality of all patients' social information.

INTERPRETIVE GUIDELINES

(c) Standard

1. Significant social service findings and actions taken are entered promptly in the patient's medical record.

2. Records of social data are available only to the attending physician, appropriate members of the nursing staff, other key personnel or to appropriate health or welfare agencies who are directly involved in the patient's care.

3. Policies are established to protect confidentiality of social service records.

4. The patient's written consent (or that of responsible person acting on his behalf) is obtained before social information is transmitted to an outside agency or individual. The consent form is filed in the patient's medical record.

SURVEY PROCEDURES

(c) Standard

1. The social services policies and procedures are reviewed to ensure that they at least cover:

   a. Type of social data to be obtained;

   b. Confidentiality of social data;

   c. Availability of data to other services; and

   d. Transmittal of data on referral.

2. The medical records reviewed are checked for pertinent social data of patient and family such as evaluation of needs, attitudes, feelings, and problems of the patient and his family, social history and background information, and recommendations for social treatment, if necessary.

STANDARD

405.1131 Condition of participation--patient activities.

The skilled nursing facility provides for an activities program, appropriate to the needs and interests of each patient, to encourage self care, resumption of normal activities, and maintenance of an optimal level of psychosocial functioning.

(a) Standard: Responsibility for patient activities. A member of the facility's staff is designated as responsible for the patient activities program. If he is not a qualified patient activities coordinator, he functions with frequent, regularly scheduled consultation from a person so qualified. (See 405.1121(i).)

INTERPRETIVE GUIDELINES

405.1131 - Patient activities

The purpose of an activities program is to create an environment that is as near to normal as possible, thereby encouraging persons in a facility to exercise their abilities. An activities program provide physical, intellectual, social, spiritual, and emotional challenges much in the same way that everyday life in the community provide challenges. It provides these challenges in a planned, coordinated, and structured manner and the activities provided are beneficial in overcoming specific problems.

(a) Standard

If the designated staff member is not a qualified patient activities coordinator, consultation is required. The frequency of consultation depends on the quality of the activities program. Consultation could range from weekly to semi-annually, depending on how well the interests and needs of the patients are met and qualifications and experience of the activities coordinator.

SURVEY PROCEDURES

405.1131 - Patient activities.

(a) Standard

1. The surveyor reviews the qualifications of the person responsible for patient activities to verify that they meet the qualifications set forth in § 405.1101(o), or if not, that there is consultation from a person so qualified.

2. The surveyor reviews the job description of the activities coordinator to verify that the responsibilities assigned are appropriate to develop the patient activities program and are commensurate with qualifications.

3. The surveyor reviews the reports of the consultant and determines the adequacy of the consultation in terms of the overall quality of the activities provided and their relationship to patients' interests and needs rather than the number of consultant visits.

4. The amount of time spent by the designated staff member in the patient activities program is reviewed to determine adequacy.

STANDARD

(b) Standard: Patient activities program. Provision is made for an ongoing program of meaningful activities appropriate to the needs and interests of patients, designed to promote opportunities for engaging in normal pursuits, including religious activities of their choice, if any. Each patient's activities program is approved by the patient's attending physician as not in conflict with the treatment plan. The activities are designed to promote the physical, social, and mental well-being of the patients. The facility makes available adequate space and a variety of supplies and equipment to satisfy the individual interests of patients (see 405.1134(g)).

INTERPRETIVE GUIDELINES

(b) Standard

1. The development of each patient's daily activities considers his/her interests, former life style, sociological, psychological and physical evaluations, and physician's recommendations.

2. Patients are not required to participate in activities if they do not desire.

3. It is not necessary that the attending physician record his approval of each activity, however, the patient activities coordinator discusses patient interests with the physician to identify limitations and modifications in the activity plans.

4. The activities coordinator is provided a list of new patients enumerating precautions on a patient's condition that may restrict or modify his participation in the program. The restrictions of each are documented in the plan of care and the medical record.

5. The attending physician and responsible nursing personnel are kept informed of the patient's participation in the various activities and significant changes in his response to activities are entered in his medical record.

6. The facility provides adequate space, supplies, and equipment for activities of interest to patients.

7. Supplies and equipment are maintained in a safe and functional order and are easily accessible to patients where feasible.

SURVEY PROCEDURES

(b) Standard

1. Verifies that there is a plan for each resident identifying his interests, needs, physician's recommendations, and methods for implementing plan. Documentation of this is attained from the patient's care plan and medical record.

2. Conversations or informal interviews are held with both bedfast and ambulatory patients to determine that they are not forced to participate in specific activities, (e.g., religious services, bingo, etc.) to evaluate appropriateness of activities to their interests and needs, and to determine adequacy of activities including weekend activities.

3. The surveyor reviews the activities schedules (past and planned) to determine the nature and frequency of activities and to assure that they include provision for religious activities, etc.

4. The activities coordinator is questioned to determine how he learns of those patients with restricted or modified activities.

5. The participation of the patients in activities is observed to verify that the program is followed.

6. The activity areas are observed to determine adequacy of funds for supplies and equipment.

7. Medical records are checked to document resident's participation and response and assure that the activities plan is periodically revised to reflect interests and needs.

8. The surveyor verifies that space is adequate and that an area for consultation is available for those patients who desire a private visit from the clergy, family, social worker, and others.

8. An activities schedule of special events and group activities is maintained for review by the administrator and director of nursing and is available to patients. The schedule identifies the location of the activity and the leader.

9. Patients are assisted to attend religious services as requested. Also patients' requests to see their clergymen are honored and appropriate arrangements are made to ensure privacy during visits.

10. Daily visiting hours are flexible and a visiting area is provided. Visiting hours are posted for the public.

STANDARD

405.1132 Condition of participation--medical records.

The facility maintains clinical (medical) records on all patients in accordance with accepted professional standards and practices. The medical record service has sufficient staff, facilities, and equipment to provide medical records that are completely and accurately documented, readily accessible, and systematically organized to facilitate retrieving and compiling information.

(a) Standard: Staffing. Overall supervisory responsibility for the medical record service is assigned to a full-time employee of the facility. The facility also employs sufficient supportive personnel competent to carry out the functions of the medical record service. If the medical record supervisor is not a qualified medical record practitioner, this person functions with consultation from a person so qualified. (See 405.1121(i).)

INTERPRETIVE GUIDELINES

405.1132 Medical records

The maintenance of a high quality of medical care and treatment of the patient of the staff is the responsibility of the administration and the complete and accurate medical record serves as evidence of the fulfillment of this responsibility. The health record is a means of first evaluating health care, and then elevating the quality of health care as well as for the purpose of providing continuity, medico-legal aspects statistics, facility planning, epidemiology, education, and training.

(a) Standard

The full time employee designated as responsible for the medical record system may have other duties, but is allotted sufficient time to ensure that the medical records are properly maintained and filed.

SURVEY PROCEDURES

405.1132 - Medical records.

(a) Standard

1. The surveyor determines if the designated staff member responsible for medical records meets the qualifications as set forth in 405.1101(1), and if not, that consultation is provided by a person so qualified.

2. The decision about the adequacy of the staffing and effectiveness of the consultant visits is based upon the overall evaluation of the medical records, the filing system, and availability of essential statistical data.

STANDARD	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
(b) Standard: Protection of medical record information. The facility safeguards medical record information against loss, destruction, or unauthorized use.	(b) Standard 1. Written policies and procedures specify who has access to medical records, under what conditions records are removed from the facility, and under what conditions medical record information may be released. 2. Written consent of the patient (or of the responsible person acting in his behalf) is required for release of medical information not authorized by law.	(b) Standard 1. The policies are reviewed to assure that they cover the confidentiality of the medical records. 2. The surveyor examines the filing and storage of the records to determine if they are protected from fire and unauthorized access, etc.

STANDARD	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
(c) Standard: Content. The medical record contains sufficient information to identify the patient clearly, to justify the diagnosis and treatment, and to document the results accurately. All medical records contain the following general categories of data: Documented evidence of assessment of the needs of the patient, of establishment of an appropriate plan of treatment, and of the care and services provided; authentication of hospital diagnoses (discharge summary, report from patient's attending physician, or transfer form), identification data and consent forms, medical and nursing history of patient, report of physical examination(s), diagnostic and therapeutic orders, observations and progress notes, reports of treatments and clinical findings, and discharge summary including final diagnosis and prognosis.	(c) Standard At a minimum the medical record contains: 1. Identification and summary sheets including patient's name, social security number, marital status, date of birth, sex, home address, and religion; name, address, and telephone number of referral agency (including hospital from which admitted), attending physician, dentist, and next of kin or other responsible person; admitting diagnosis, final diagnosis, condition on discharge, and disposition, and any other information necessary to meet State requirements or as deemed necessary by the facility; 2. The patient's final diagnosis, as it appears in the hospital or other health care facility discharge summary (a report given by the physician who attended the patient in the hospital, or a transfer form used under a transfer agreement) (see 405.1133(a)); for patients admitted from the community, a physician's summary and final diagnosis; 3. Current medical evaluation, including medical history, physical examination, mental status, diagnosis, and estimation of rehabilitation potential; 4. Physicians' orders, including those pertaining to medications, treatments, diet, and restorative and special medical procedures required for the safety and well-being of the patient; 5. Progress notes written and signed at the time of each visit, e.g., notes by physicians, social workers, therapists, etc.	(c) Standard 1. The surveyor reviews a random sample of closed records (depending upon the size of the facility and the total number of medical records) that is adequate to evaluate the completeness of information, recording of services rendered, and content as specified in this standard. 2. In assessment of other service(s) records, the surveyor reviews a sampling of current records for compliance with the requirements of the specific service and the content in this standard.

STANDARD	INTERPRETIVE GUIDELINES	SURVEY
	6. Nurses notes, signed at time of entry, descriptive of the nursing care provided, nursing history and assessment of observations of symptoms, reactions to treatments and medications, and changes in the patient's physical or emotional condition; 7. Medication and treatment record, including all medications, treatments and special procedures; 8. Signed and dated laboratory, X-ray reports; 9. Signed reports and evaluations on services and consultations from other health professionals, such as dentists, social workers, dietitians, mental health personnel, and other therapists; 10. Medications given to the patient upon discharge; and 11. Discharge summary, completed by the physician promptly after the patient's discharge.	
(d) Standard: Physician documentation. Only physicians enter or authenticate in medical records opinions that require medical judgment (in accordance with medical staff bylaws, rules, and regulations, if applicable). Each physician signs his entries into the medical record.	(d) Standard	(d) Standard 1. In reviewing the records, the surveyor verifies that the physician has entered and signed medical information. 2. If the records contain a rubber stamp signature, the surveyor verifies that the facility has a statement from the physician that ensures that he alone has the right to use the stamp and that the stamp is kept in his possession.

STANDARD	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
(e) Standard. Completion of records and centralization of reports. Current medical records and those of discharged patients are completed promptly. All clinical information pertaining to a patient's stay is centralized in the patient's medical record.	(e) Standard 1. The signed original or legible copy with an original signature on each report is filed in the medical record. 2. Admission orders, admitting diagnosis, initial progress notes, medical and nursing history, and physical examination are completed and show the date of recording. 3. Where discharge summaries and other information have been dictated, the final report indicates the date of dictation and the date of transcription. 4. Medical records of discharged patients are completed as soon as possible, consistent with good medical practice.	(e) Standard The surveyor verifies that medical records are completed in a timely manner and all information about a patient is filed together.
(f) Standard: Retention and preservation. Medical records are retained for a period of time not less than that determined by the respective State statute, the statute of limitations in the State, or 5 years from date of discharge in the absence of a State statute, or, in the case of a minor, 3 years after the patient becomes of age under State law.	(f) Standard The facility has a written policy governing the retention of records.	(f) Standard The policy manual is reviewed to determine that retention and preservation of medical records are covered.

STANDARD	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
(g) Standard: Indexes. Patient's medical records are indexed according to name of patient and final diagnoses to facilitate acquisition of statistical medical information and retrieval of records for research or administrative action.	(g) Standard 1. Patient index cards contain at least the full name of the patient, address, date of birth, and the medical record number. 2. Basic information to be indexed by diagnosis (International Classification of Diseases Adapted) includes medical record number, age, sex, physician, and length of stay. Such indexing is completed as soon as possible. 3. Basic statistical medical information is maintained for use by the utilization review committee, in accordance with the facility's medical record policies and procedures.	(g) Standard The surveyor verifies that the medical records are properly indexed and readily retrievable by asking for records of different diagnoses.
(h) Standard: Location and facilities. The facility maintains adequate facilities and equipment, conveniently located, to provide efficient processing of medical records (reviewing, indexing, filing, and prompt retrieval).	(h) Standard A medical records storage area should be easily accessible and have sufficient filing equipment that is resistive to damage from fire, water, and insects.	(h) Standard The surveyor determines if the facilities, equipment, etc. are adequate to allow an effective functioning medical record system and safeguard the retention of the records.

STANDARD

405.1133 Condition of participation--transfer agreement.

The skilled nursing facility has in effect a transfer agreement with one or more hospitals approved for participation under the programs, which provides the basis for effective working arrangements under which inpatient hospital care or other hospital services are available promptly to the facility's patients when needed. (A facility that has been unable to establish a transfer agreement with the hospital(s) in the community or service area after documented attempts to do so is considered to have such an agreement in effect.)

(a) Standard: Patient transfer. A hospital and a skilled nursing facility shall be considered to have a transfer agreement in effect if, by reason of a written agreement between them or (in case the two institutions are under common control) by reason of a written undertaking by the person or body which controls them, there is reasonable assurance that:

(1) Transfer of patients will be effected between the hospital and the skilled nursing facility, ensuring timely admission, whenever such transfer is medically appropriate as determined by the attending physician, and

INTERPRETIVE GUIDELINES

405.1133 Transfer agreement

(a) Standard

The agreement:

1. Is in writing and is signed by persons authorized to execute such agreement on behalf of the institutions. Each institution maintains a copy of the agreement.

2. Ensures the interchange of medical and other information necessary or useful in the care and treatment of patients transferred between the institutions, or in determining whether such patients can be adequately cared for;

SURVEY PROCEDURES

405.1133 - Transfer agreement.

(a) Standard

1. The surveyor documents that the skilled nursing facility has in effect a transfer agreement with one or more hospitals to ensure the continuity of patient care, and that the agreement:

   a. Is in line with policies and procedures developed by the administrative body of the facility;

   b. Delineates the responsibilities assumed by both the discharging and receiving institutions;

   c. Makes arrangements for safe transportation and care of the patients during transfer;

   d. Requires the transfer of personal effects, particularly money and valuables and for information related to his medical status;

   e. Ensures that all services required for the continuity of patient care are promptly made available for the patient; and

STANDARD	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
(2) There will be interchange of medical and other information necessary or useful in the care and treatment of individuals transferred between the institutions, or in determining whether such individuals can be adequately cared for otherwise than in either of such institutions, and (3) Security and accountability for patients' personal effects are provided on transfer. Any skilled nursing facility which does not have such agreement in effect, but which is found by a State agency (of the State in which such facility is situated) with which an agreement under section 1864 is in effect (or, in the case of a State in which no such agency has an agreement under 1864, by the Secretary) to have attempted in good faith to enter into such an agreement with a hospital sufficiently close to the facility to make feasible the transfer between them of patients and the information referred to in paragraph (a)(2) of this section, shall be considered to have such an agreement in effect if and for so long as such agency (or the Secretary, as the case may be) finds that to do so is in the public interest and essential to ensuring skilled nursing facility services for persons in the community who are eligible for payments with respect to such services under the programs.	3. Specifies the responsibilities assumed by both the discharging and receiving institutions for prompt notification of the impending transfer of the patient, for agreement by the receiving institution to admit the patient, for arranging appropriate and safe transportation and care of the patient during transfer, and for the transfer of personal effects, particularly money and valuables, and of information related to such items; and 4. Specifies restrictions with respect to the types of services available and/or the types of patients or health conditions that will not be accepted by the hospital or the facility, or includes any other criteria relating to the transfer of patients (such as priorities for persons on waiting lists), such restrictions or criteria are the same as those applied by the hospital or facility to all other potential inpatients of either institution.	f. Is with a hospital close enough to make the transfer of patients feasible and safe. 2. The hospital's provider, or vendor number is verified either before or after the survey to ascertain that it has been approved to participate in the Federal program. 3. The policy and/or procedural manual is reviewed to establish that: a. Communication networks have been identified for notifying the appropriate persons (attending physician, next of kin, or responsible person) when transfers are anticipated; b. Arrangements are made for the transfer of pertinent medical and other information which accompany the patient between the two facilities; and c. A responsible person is delegated to initiate the transferral process. 4. The surveyor talks with the administrator and charge nurse to assess their familiarity with the facility's policies and procedures. 5. To justify that a skilled nursing facility qualifies for a waiver of this condition, the surveyor must establish that there is no hospital servicing the area, or if there is one, and an attempt to enter in an agreement was unsuccessful, the endeavor is documented by reviewing letters or records of the conference.

STANDARD

405.1134 Condition of participation physical environment.

The skilled nursing facility is constructed, equipped, and maintained to protect the health and safety of patients, personnel, and the public.

(a) Standard: Life safety from fire. The skilled nursing facility meets such provisions of the Life Safety Code of the National Fire Protection Association (21st Edition, 1967) as are applicable to nursing homes; except that, in consideration of a recommendation by the State survey agency, the Secretary may waive, for such periods as deemed appropriate, specific provisions of such Code which, if rigidly applied, would result in unreasonable hardship upon a skilled nursing facility, but only if such waiver will not adversely affect the health and safety of the patients; and except that the provisions of such Code shall not apply in any State if the Secretary finds, in accordance with applicable provisions of section 1861 (j)(13) of the Social Security Act, that in such State there is in effect a fire and safety code, imposed by State law, which adequately protects patients in skilled nursing facilities. Where waiver permits the participation of an existing facility of two or more stories which is not of at least 2-hour fire resistive construction, blind, non-ambulatory, or physically handicapped patients are not housed above the street level floor unless the facility is of 1-hour protected noncombustible construction (as defined in National Fire

[illegible]

405.1134 Physical Environment

(a) Standard

1. The facility must comply with the Life Safety Code Standards of the Institutional Occupancy, chapter 10 and those provisions in chapters 1 through 7, and 17, and appendix B as are applicable to nursing homes. This determination will be made by a Life Safety Code survey.

2. "The fire safety manual for Nursing Homes," published by the American Nursing Home Association under contract number HSM 110-73-363, and sponsored by the Health Services and Mental Health Administration of DHEW provides a ready reference to assist in implementation of fire safety practices within the facility.

[illegible]

405.1134 Physical [illegible]

(a) Standard

1. There is a special Life Safety Code survey to evaluate this standard.

Protection Association Standard No. 220), fully sprinklered 1-hour protected ordinary construction, or fully sprinklered 1-hour protected woodframe construction. Nonflammable medical gas systems, such as oxygen and nitrous oxide, installed in the facility comply with applicable provisions of National Fire Protection Association Standard No. 56B (Standard for the Use of Inhalation Therapy) 1968 and National Fire Protection Association Standard No. 56F (Nonflammable Medical Gas Systems) 1970.

(b) Standard: Emergency power. The facility provides an emergency source of electrical power necessary to protect the health and safety of patients in the event the normal electrical supply is interrupted. The emergency electrical power system must supply power adequate at least for lighting in all means of egress; equipment to maintain fire detection, alarm, and extinguishing systems; and life support systems. Where life support systems are used, emergency electrical service is provided by an emergency generator located on the premises.

(b) Standard

1. A life support system is that electrical equipment used to maintain the life of patients dependent upon such equipment. These patients are, therefore, electrically dependent for continuation of life and are being treated with externalized electrical conductors such as probes, catheters, and other electrodes connected to the heart. This equipment would also include dialysis machines, respirators, and aspirators (when the patient is dependent upon same). The condition of these patients is such that interruption of electrical power to this equipment could result in death or irreparable damage.

(b) Standard

1. The emergency electrical power system is checked during the life safety survey; no determination is made by the health surveyor except as pertaining to emergency generator for life support systems.

2. If the facility has a life support system, the surveyor verifies that there is a plan for regular testing of the emergency generator and that the plan is being followed.

3. To check the emergency generator for life support systems, the surveyor follows these steps (ONLY IF THERE IS NOT A PATIENT IN THE FACILITY USING SUCH EQUIPMENT):

2. A skilled nursing facility may, or may not, designate a separate patient area in the facility where life support systems are located. If there is an area so designated, this area must be tied into an emergency power supply. Where there is no designated area, but life support equipment is provided in the skilled nursing facility, there must be a sufficient number of power outlets for such equipment which are tied into an emergency power supply. In all cases, an onsite emergency generator is required to assure emergency power to life support equipment.

3. The emergency electrical system shall be so controlled that after interruption of the normal electrical power supply, the generator is brought to full voltage and frequency within 10 seconds through one or more primary automatic transfer switches to life support system equipment.

   (a) Request that a staff member cut off power in the facility and activate the emergency generator;

   (b) Connect the life support equipment to the outlet(s) designated as tied into the emergency power supply, to determine if the emergency power system is functional.

4. If there is a patient using such equipment in the facility, the generator is not tested; the administrator's assurance and maintenance records on the generator will be sufficient.

(c) Standard: Facilities for physically handicapped. The facility is accessible to, and functional for, patients, personnel, and the public. All necessary accommodations are made to meet the needs of persons with semiambulatory disabilities, sight and hearing disabilities, disabilities of coordination, as well as other disabilities, in accordance with the American National Standards Institute (ANSI) Standard No. A117.1, American Standard Specifications for Making Buildings and Facilities Accessible to, and Usable by, the Physically Handicapped. The Secretary (or in the case of a facility participating as a skilled nursing facility under title XIX only, the survey agency--see 249.33(a)(1)(i) of this title) may waive in existing buildings, for such periods as deemed appropriate, specific provisions of ANSI Standard No. A117.1 which, if rigidly enforced, would result in unreasonable hardship upon the facility, but only if such waiver will not adversely affect the health and safety of patients.

(c) Standard

1. The following references are to sections in ANSI A117; and, cross-references marked LSC are to the Life Safety Code Survey Report Form (SSA-2786) where appropriate. (Parenthetic remarks provide supplementary interpretations.)

   4.1 Are the facility grounds graded to the same level as the primary entrance so that the building is accessible to the physically handicapped?

   4.2 Is the width and grade of walks used by patients and public designed so that they can be utilized by the handicapped?

   4.3 If the facility has a parking lot, is properly designated parking space available near the building, allowing room for the physically handicapped to get in and out of an automobile onto a surface suitable for wheeling and walking? (Sufficient space for a handicapped driver to enter or leave an average size car is 12 feet.)

   5.1 Are ramps designed so that they can be easily negotiated by individuals in wheelchairs? (Railings, preferably on both sides of the ramp, become particularly important the longer the ramp and the steeper the grade. Ramps approaching doors should have level platforms large enough to accommodate a wheelchair.)

(c) Standard

1. For purposes of this standard, the intent of A117.1 is to ensure that all persons, (patients, staff, and public) can function in a skilled nursing facility. Therefore, the specifities, i.e., door widths, water fountain heights, are not the paramount consideration. Rather the surveyor must evaluate the accessibility of the total environment, such as, are the doors wide enough to accommodate wheelchairs, are the doors operable by a single effort, are the ramps too steep to be negotiated by individuals in wheelchairs? In short, the building, its grounds, and its facilities should permit a physically handicapped person to go about his daily routine unassisted and should not prevent him from functioning within his capabilities.

2. Through observation, the surveyor should be able to judge whether architectural barriers prevent the physically handicapped from moving around the building, entering and leaving the building, or using the telephones, etc. When checking toilet facilities, for instance, the following questions should be kept in mind:

   a. In the toilet rooms, is there at least one stall designed and equipped for someone in a wheelchair to enter the stall, close the stall door or curtain, and transfer to the water closet?

   b. Are lavatories in these toilet rooms usable by individuals in wheelchairs?

   c. Of these toilet rooms, are those for men equipped with appropriately mounted urinals?

   d. Are towel and other dispensers, racks, and mirrors in these toilet rooms mounted at heights that permit use by those in wheelchairs?

5.2 Is there a primary entrance usable by persons in wheelchairs? (LSC-SRF 3-5) (A primary entrance need not be the front door, but at the same time, it is not intended that the handicapped person must enter through service areas such as the kitchen or laundry.

5.3 Are doors used by patients and public of sufficient width and so equipped and of a weight to permit persons in wheelchairs to open them with a single effort? (A single effort door is one that will not spring back and immediately lock when released).

5.4.1 Are stairs that may be used by the physically handicapped of a height and design that allows such individuals to negotiate them without assistance? (Steep nosings should not protrude. If stairs would not be used by handicapped persons even in emergencies, it is not necessary that the stairs meet this requirement).

5.4.3 Are these stairs equipped with handrails, at least one of which extends past the top and bottom steps?

5.5 Are floors non-slip and on a common level or connected by a negotiable ramp on each story?

5.6 Is there an appropriate number of toilet rooms accessible to and usable by the handicapped?

5.7 Is there an appropriate number of water fountains accessible to and usable by the handicapped?

5.8 Is there an appropriate number of public telephones accessible to and usable by the handicapped?

5.9 If a multi-story building, are elevators accessible to and usable by the handicapped, at entrance level and all levels normally used by the public? (LSF-SRF 7-4)

3. The ANSI standard was written for architects and thus is directed more towards the design and construction of new buildings. For this reason the ANSI standard permits waivers and these regulations provide that waivers may be granted for existing buildings. (See § 405.1101(j) for definition of existing buildings). When recommending ANSI waivers for existing buildings, the surveyor applies the following criteria:

a. Waiver of the particular feature of ANSI A117.1 will not endanger the health or safety of the beneficiary; and

b. Correction of the deficiency would result in an unreasonable hardship upon the facility, i.e., cause substantial financial burden.

An appropriate period for granting a waiver is usually until the next scheduled survey at which time the waiver should be reassessed. If use of the facility and the reason for initially granting the waiver have not changed, it should be possible at the time of the subsequent surveys, to reissue appropriately granted waivers.

Some examples of waiver possibilities are cited below:

(1) Section 5.9 of ANSI A117.1 requires elevators in multi-story buildings. However, in such buildings, if handicapped persons are housed only on the first floor and all services ordinarily offered by the facility, i.e., cafeteria, physical therapy, patient activities, etc., are also located on the first floor, financial hardship can be assumed since the installation of elevators always involves a substantial outlay of capital and a significant disruption of activities. In this situation a waiver should be considered.

5.10 Are switches and controls of frequent or essential use within reach of wheelchair users?

5.11 Does the facility provide appropriate means for the blind to identify rooms, facilities, and hazardous areas?

5.12 Does the facility provide simultaneous audible and visual warning signals? (LSC-SRF 6-1)

5.13 Does the facility exercise safeguards to eliminate hazards for the handicapped?

Are patient closets accessible to and usable by the physically handicapped? Are patient beds of a height that permits an individual in a wheelchair to get in and out of bed unassisted?

1. These questions recognize the needs of the physically handicapped as they attempt to function in an environment that is seldom designed with them in mind. Most buildings and grounds do not tolerate the needs of those with mobility limitations. As a result, the physically handicapped are frequently isolated from society because they cannot move about or use the same buildings and grounds. The adoption of ANSI A117.1 represents an effort to prevent this enforced isolation of the physically handicapped; to correct or forestall the erection of architectural barriers that in effect fence off the physically handicapped from their fellow citizens.

2. To facilitate the survey, the questions on the survey form were expressed in general terms. Certain phrases are used to convey the purpose of various sections of A117.1. These phrases are defined below:

(2) Doors may be less than 32 inches when opened as required by section 5.3.1 of ANSI A117.1. However, most wheelchairs are 25 to 26 inches wide and if a facility comes close to meeting the requirement, e.g., 30 to 31 inch door openings, wheelchair patients should be able to pass through the opening. (While the ANSI standard requires only 32-inch door openings, it should be recalled that the LSC calls for 40 inches in clear width to patients' sleeping rooms).

(3) Public telephones are required by section 5.8 of ANSI A117.1. This requirement could certainly be considered for waiver, if the criteria above are met when each patient has his own telephone.

(4) Warning signals are almost without exception audible. Simultaneous visible warning signals (ANSI 5.12) may be waived in an institutional occupancy where staff is responsible for directing patients with hearing handicaps in the event of an emergency.

(5) Where waivers have been previously granted by individuals performing Life Safety Code surveys and accepted by the appropriate authorities, and the waiver covers a provision of ANSI A117.1, it may not be necessary to prepare another waiver. A judgment must be made by the person doing the ANSI review whether or not the waiver violates the intent of ANSI A117.1. If it appears that the ANSI reviewer could not rationalize a previously granted LSC waiver, it will be necessary to reevaluate the waiver decision in light of ANSI A117.1, for example, some 27-inch width doors were accepted for waiver by a LSC inspector, and these doors are used by persons in wheelchairs, this may well violate the intent of ANSI A117.1. If, however, the LSC waiver is

a. Accessible and usable--Placed in a manner that can be utilized by and convenient to persons in a wheelchair, on crutches, or otherwise handicapped, e.g., the telephones, water fountains, elevator buttons, toilets, etc. shall be so positioned and at a height that a person in a wheelchair can readily approach and dial the phone, drink from the fountain, push the elevator button, or transfer to the water closet seat.

b. Appropriate means--Compensative features be provided to enable persons with different disabling conditions to utilize the facilities of the institution.

c. Appropriate number--In this reference, appropriate number means the number of specific items (telephones, toilet rooms, water fountains, etc.) necessary to allow the physically handicapped to function while in the SNF. There should be sufficient facilities to accommodate all physically handicapped, whether patients, staff, or public. For example, there should be a sufficient number of properly equipped toilet facilities for physically handicapped patients as well as for physically handicapped visitors and staff. The number of such facilities needed is judged in relation to the physically handicapped population requiring them.

d. Eliminate hazards--The facility shall make every effort to do away with hazardous conditions, which, due to construction or design features, cannot be changed. The hazard is called to the attention of the handicapped person and necessary action is taken to eliminate the potential danger resultant from the condition, e.g., by providing ramps, guardrails, barricades, and other aids as appropriate.

allowed to stand, the necessary documentation can be accomplished by annotating the health survey form by reference to the authority and date by which the LSC waiver was previously granted. Any health-related rationale should be included, if appropriate.

(6) Documentation of unreasonable hardship--necessary for waiver determination should include:

a. Estimated cost of the installation;

b. Availability of financing;

c. Remaining useful life of building; and

d. Description of patient care and services.

STANDARD

(d) Standard: Nursing unit. Each nursing unit has at least the following basic service areas: Nurses station, storage and preparation area(s) for drugs and biologicals, and utility and storage rooms that are adequate in size, conveniently located, and well lighted to facilitate staff functioning. The nurses station is equipped to register patients' calls through a communication system from patient areas, including patient rooms and toilet and bathing facilities.

INTERPRETIVE GUIDELINES

(d) Standard

1. The medication preparation area provides adequate space and equipment, with proper lighting, ventilation, temperature controls, and hot and cold running water.

2. Separate toilet and handwashing facilities are available for nursing personnel.

3. Adequate and sanitary space is provided for handling and storage of clean linen, clothing, and supplies. (See 405.1135(d))

4. Stretchers, wheelchairs, walkers, and other such equipment are readily available.

5. Each patient bed has a nurses call signal that registers at the nurses station.

LEVEL - [illegible]

(d) Standard

A tour of the nursing unit is required to determine that the unit is adequate in size and space, has sufficient storage areas, and that the service facilities are clean, orderly, and functional.

1. Criteria on which judgments are made about the adequacy of size and space require the surveyor to:

   a. Check the work areas and ascertain that they allow staff movement without obstruction and drug preparation without interference; and

   b. Observe storage area to make sure that clean, soiled, and isolation areas are adequately separated.

2. Functional design of the nursing unit is checked to ascertain that:

   a. A communication or call system between the patient's bedroom, bath, and nursing station is operable and can only be disconnected at the source of the call;

   b. There is adequate lighting at the nursing unit and the drugs and biologicals preparation area; and

   c. Drug cabinets and storage areas are safeguarded, routinely checked, and are properly lighted and ventilated.

3. The service facility work areas are checked for orderliness and cleaniness.

STANDARD	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
(e) Standard: Patient rooms and toilet facilities. Patient rooms are designed and equipped for adequate nursing care and the comfort and privacy of patients, and have no more than four beds, except in facilities primarily for the care of the mentally ill and/or retarded where there shall be no more than 12 beds per room. (An institution primarily engaged in the care of the mentally retarded or in the treatment of mental diseases cannot qualify as a participating skilled nursing facility under Medicare.) Single patient rooms measure at least 100 square feet, and multipatient rooms provide a minimum of 80 square feet per bed. The Secretary (or in the case of a facility participating as a skilled nursing facility under title XIX only, the survey agency--see 249.33(a)(1)(i) of this title) may permit variations in individual cases where the facility demonstrates in writing that such variations are in accordance with the particular needs of the patients and will not adversely affect their health and safety. Each room is equipped with, or is conveniently located near, adequate toilet and bathing facilities. Each room has direct access to a corridor and outside exposure, with the floor at or above grade level.	(e) Standard 1. Each patient has an individual reading light, bedside cabinet, comfortable chair, and storage space for clothing and other possessions. Each patient room has a night light. To ensure privacy in multipatient rooms, each bed has flame retardant cubical curtains, partitions or freestanding folding screens. 2. Each patient room has handwashing facilities with both hot and cold running water, unless provided in adjacent room. The temperature of hot water accessible to patients should comply with State requirements and be automatically regulated by control valves. 3. At least one toilet, enclosed in a separate room or stall and equipped with a nurses call signal, provided for each eight beds is considered adequate. 4. Each floor has at least one toilet room and shower stall large enough to accomodate a wheelchair and patient transfer. 5. Each bathtub or shower is equipped with a nurses call signal and ensures patient privacy. At least one bathing facility is large enough to accommodate a wheelchair and attendant.	(e) Standard 1. The surveyor verifies that each: a. Patient room has an individual reading light, comfortable chair, and storage space for clothing and other possessions; b. Floor has at least one toilet room large enough to accommodate a wheelchair and patient transfer; and c. Although the Federal regulations do not set forth a specific temperature for the hot water, the surveyor must test the water to determine if it meets applicable State standards, is within a safe temperature range; and is automatically controlled. 2. When a waiver is requested, the surveyor submits data required to substantiate or deny the waiver.

6. Secured and conveniently located grab bars and other safeguards against slipping are installed in all toilet and bathing compartments.

7. Waivers are permitted under the standard in appropriate situations for the number of patients in rooms and/or room sizes.

STANDARD	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
(f) Standard: Facilities for special care. Provision is made for isolating patients as necessary in single rooms ventilated to the outside, with private toilet and handwashing facilities. Procedures in aseptic and isolation techniques are established in writing and followed by all personnel. Such areas are identified by appropriate precautionary signs.	(f) Standard (See also 405.1135(b)) 1. Contaminated laundry is kept in clearly marked bags and handled separately. 2. If nondisposable dishes and flatware are used in serving patients in isolation, they are kept clearly marked and handled separately. If disposables are used, they are placed in clearly marked containers and promptly destroyed. 3. Staff, visitors, and others in contact with patients with infectious diseases use isolation techniques that are appropriate for the type of disease.	(f) Standard Attention is given to the operational and procedural arrangements made for isolated patients requiring special care (405.1135). The surveyor observes that: 1. Isolated areas are identified by appropriate signs; 2. Written procedures in aseptic and isolation techniques are accessible to the personnel (question them to ascertain their familiarity with the procedures if there is a patient in isolation); and 3. Patients are kept in a single, well-vented room having separate toilet and handwashing facilities.
(g) Standard: Dining and patient activities rooms. The facility provides one or more clean, orderly, and appropriately furnished rooms of adequate size designated for patient dining and for patient activities. These areas are well-lighted and well-ventilated. If a multi-purpose room is used for dining and patient activities, there is sufficient space to accommodate all activities and prevent their interference with each other.	(g) Standard 1. The recreation and dining areas should accommodate the needs of both wheelchair users and ambulatory patients, so that wheelchair bound patients can congregate with ambulatory patients and freely participate in activities. 2. There should be sufficient space between tables for freedom of movement so that patients are not forced because of the lack of space to depend upon staff members for patient activities, materials, and equipment.	(g) Standard 1. When possible, the surveyor talks with patients to ascertain their feelings about the attractiveness and convenience of the patient activities and dining rooms. Other assessments required about which the patient is likely to be less knowledgeable include: a. Light levels which are adequate and void of high brightness, glare, and reflecting surfaces that produce discomfort; and b. Sufficient ventilation through the use of windows, mechanical ventilation, or a combination of both. 2. The surveyor observes the use of the room at mealtime to determine if it is adequate in size to accommodate the patients willing and able to go to the dining room.

(h) Standard: Kitchen and dietetic service areas. The facility has kitchen and dietetic service areas adequate to meet food service needs. These areas are properly ventilated, and arranged and equipped for sanitary, refrigeration, storage, preparation, and serving of food as well as for dish and utensil cleaning and refuse storage and removal.

(h) Standard

1. Food preparation area is designated for the separation of functions. Meat and vegetable preparation areas are separated.

2. Handwashing facilities in the kitchen are separate from food preparation and dishwashing equipment, and include hot and cold water with a mixing valve or combination faucet, soap, and disposable towels.

3. All floors in food preparation and storage areas are washable and have a nonslip finish. Walls and ceilings are washable; walls in the immediate area of plumbing fixtures are of moistureproof finish.

4. Wood chopping blocks are not used and meat cutters are cleaned daily, ranges and range hoods are free of accumulated grease and dust.

5. Refrigerators and/or freezers are periodically cleaned and food is arranged on the shelves in an orderly and sanitary fashion.

6. The kitchen is located to permit efficient service to patients and is used only for dietetic functions. Non-dietary employees are not permitted in the kitchen area, except as specifically required.

(h) Standard

In addition to the observations and reviews covered under the Standard (405.1125(g)) for Dietetic Services, the surveyor verifies that:

1. Windows and doors leading to the outside are appropriately screened; and

2. Garbage and trash are stored in areas separate from those used for the preparation and storage of food and are removed in conformance with State and local practices.

(i) Standard: Maintenance of equipment, building, and grounds. The facility establishes a written preventive maintenance program to ensure that equipment is operative and that the interior and exterior of the building are clean and orderly. All essential mechanical, electrical, and patient care equipment is maintained in safe operating condition.

(i) Standard

1. A current and realistic preventive maintenance program is in effect.

2. Patient care equipment is routinely serviced to ensure that it is maintained in a safe, sanitary, and operative manner, e.g., wheelchairs, food service carts, bedside stands, etc. Plumbing, heating, and the essential equipment are routinely maintained and functioning.

(i) Standard

The surveyor in evaluating this standard:

a. Observes both the interior and exterior of the building to ascertain that the building is clean, orderly, and attractive;

b. Inspects the building, patient care equipment and maintenance schedules to find out if a preventive maintenance program is in effect; and

c. Checks patient care equipment to ensure that it is maintained in a safe and operable manner.

	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
(j) Standard: Other environmental considerations. The facility provides a functional, sanitary, and comfortable environment for patients, personnel, and the public. Provision is made for adequate and comfortable lighting levels in all areas, limitation of sounds at comfort levels, maintaining a comfortable room temperature, procedures to ensure water to all essential areas in the event of loss of normal water supply, and adequate ventilation through windows or mechanical means or a combination of both. Corridors are equipped with firmly secured handrails on each side.	(j) Standard 1. Lighting levels in all areas of the facility are adequate and void of glare and reflecting surfaces that produce discomfort. 2. Sounds (impact noise, airborne sound) are minimized to a level that ensures patient comfort. 3. The heating system is capable of maintaining a comfortable temperature at least 3 feet above the floor. 4. Adequate supplies of water are available to meet the immediate needs of the patients (e.g., administration of medications and preparation of food) in case of emergency disaster. The availability of community resources is investigated by the facility, e.g. arrangements for a tank truck when extensive disruption of water supply occurs; for short-term disruptions, civil defense containers of water, properly prepared and stored will suffice. It is not necessary that an emergency reservoir be installed. 5. Adequate ventilation is considered to be two air exchanges per hour in a room. In existing buildings, this can be accomplished through windows that open onto an outside area, exhaust fans in rooms without outside windows, door cuts, and louvered doors (when not prohibited by Life Safety Code). New buildings should have provisions for an appropriate number of air exchanges incorporated into their air handling systems.	(j) Standard 1. The surveyor verifies that heating and air conditioning systems are capable of maintaining adequate temperatures and providing freedom from drafts. 2. Through a tour of the facility, the surveyor determines the adequacy of light in the various areas. 3. The surveyor checks to see that those windows that can be opened have screens. 4. To assess ventilation in an existing building, the surveyor checks the windows to determine that they open onto an outside area. (Windows need not be actually open; normal air leakage through the panes and around the frames will provide air exchange.) Windows opening onto enclosed porches or small court yards would not meet this requirement. Rooms without outside windows should have other air exchange provisions as discussed in the guidelines. In a new building, the surveyor reviews the building plans to determine that provisions for air exchange were part of its air exchange system.

405.1135 Condition of participation-infection control.

The skilled nursing facility establishes an infection control committee of representative professional staff with responsibility for overall infection control in the facility. All necessary housekeeping and maintenance services are provided to maintain a sanitary and comfortable environment and to help prevent the development and transmission of infection.

(a) Standard: Infection control committee. The infection control committee is composed of members of the medical and nursing staffs, administration, and the dietetic, pharmacy, housekeeping, maintenance, and other services. The committee establishes policies and procedures for investigating, controlling, and preventing infections in the facility, and monitors staff performance to ensure that the policies and procedures are executed.

405.1135 Infection control

(a) Standard

1. The infection control committee develops written policies and procedures for the prevention and control of infections, maintenance of a sanitary environment, and techniques and systems for identifying infections in the facility, with procedures for reporting to appropriate governmental authorities.

2. The committee:

   a. Reviews the handling of food, laundry practices, disposal of environmental and patient wastes, pest control, traffic control, visiting rules for high-risk areas, and sources of airborne infection;

   b. Should meet at least quarterly, submit reports to the administrator, and maintain minutes in sufficient detail to document its proceedings and actions; and

405.1135 - Infection control.

To determine whether the infection committee is actively involved in developing written policies and procedures for maintaining a sanitary environment, the surveyor reviews the committee's minutes and reports, talks with the administrator, director of nursing, dietitian, etc., and actually observes, when possible, the use of aseptic techniques and procedures.

(a) Standard

1. The surveyor:

   a. Reads the statement of the committee's functions, membership, and frequency of meetings and the minutes of the meetings to determine that all required personnel are participating and that the functions of the committee are being carried out.
   b. Reviews the written policies to establish whether (1) responsibility has been formally delegated for supervision and coordination of the infection control activities; (2) recommendations exist for a reporting system which accounts for actions taken by the committee; and (3) adequate channels of communication are specified for providing feedback to the administrator.
   c. Checks the procedures developed for accomplishing the infection control objectives to ascertain that they contain, at a minimum:
      (1) General precautions to be used in isolated rooms or units;
      (2) Methods of care for isolated patients;
      (3) Methods for protecting personnel and visitors;
      (4) Methods for servicing isolated units;
      (5) Requirements on wearing uniforms in the facility to prevent transporting infection agents; and
      (6) Methods used for regular surveillance of high risk areas.

c. Monitors the health status of employees, includes, but is not limited to:

(1) Provision of, or referral for, periodic examination for employees, including X-ray and/or tuberculin tests.

(2) Periodic dissemination of current information on health practices to all employees.

d. Monitors the health and environmental aspects of the facility through:

(1) Periodic review of infection control techniques for food service and laundry personnel.

(2) Review and observation of techniques employed in maintenance of equipment, machines, water fountains, etc.

(b) Standard: Aseptic and isolation techniques. Written effective procedures in aseptic and isolation techniques are followed by all personnel. Procedures are reviewed and revised annually for effectiveness and improvement.

(b) Standard

(b) Standard

1. The surveyor reviews the aseptic procedures developed f control of infection, observes whether these procedures are readily available, questions the staff to determine their knowledge of infection control techniques in relation to their responsibility for care of an isolated patient.

2. The orientation program is reviewed to ascertain if aseptic techniques were included.

3. The minutes of the committee are checked to verify that the procedures are reviewed at least annually.

STANDARD	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
(c) Housekeeping. The facility employs sufficient housekeeping personnel and provides all necessary equipment to maintain a safe, clean, and orderly interior. A full-time employee is designated responsible for the services and for supervision and training of personnel. Nursing personnel are not assigned housekeeping duties. A facility that has a contract with an outside resource for housekeeping services may be found to be in compliance with this standard provided the facility and/or outside resource meets the requirements of the standard.	(c) Standard If the full-time employee designated as responsible for the housekeeping service is assigned other duties, sufficient time is allotted to supervise the maintenance of a clean and orderly environment.	(c) Standard The surveyor assesses the sufficiency of time and personnel allotted for maintaining a safe, clean, orderly, and attractive interior by: 1. Determining whether the facility is clean, orderly, and free from offensive odors; 2. Reading the job description of the person designated as supervisor to verify that the responsibility for the housekeeping service is clearly delineated; and 3. Reviewing the written policies and procedures of the housekeeping service and through observation of the actual cleaning process, verify that the procedures are being met.
(d) Standard: Linen. The facility has available at all times a quantity of linen essential for proper care and comfort of patients. Linens are handled, stored, processed, and transported in such a manner as to prevent the spread of infection.	(d) Standard 1. The linen supply should be adequate for the number of occupied beds and requirements should vary dependent upon the type of patient. Arrangements should also be made to provide an adequate supply of linen for long weekends. 2. Sorting of soiled linen, laundering, and extraction is separated from the ironing, folding, and storage of clean linen. Separate rooms, if available, and reverse exhaust fans are utilized to prevent cross contamination. 3. Clean linen and clothing are stored in clean, dry, and dust-free areas and easily accessible to the nurses station. 4. Soiled linen and clothing are placed in suitable bags or containers in well-ventilated areas, separated from clean linen, and are not permitted to accumulate in the facility.	(d) Standard Surveying the facility with respect to this standard requires the surveyor to observe: 1. Availability of linen, in terms of census, number of bedfast patients, and number of incontinent patients; 2. Adequacy of storage area; and 3. Transportation of linen, e.g., separate hampers for clean and soiled linen, clean linen covered in transit.

STANDARD	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
(e) Standard: Pest control. The facility is maintained free from insects and rodents through operation of a pest control program.	(e) Standard	(e) Standard The surveyor reviews the pest control program and assesses its effectiveness during the tour of the facility with special attention to the food storage areas, refuse containers, patient areas, and entrances.

STANDARD	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
405.1136 Condition of participation--disaster preparedness. The skilled nursing facility has a written plan, periodically rehearsed, with procedures to be followed in the event of an internal or external disaster and for the care of casualties (patients and personnel) arising from such disasters. (a) Standard: Disaster plan. The facility has an acceptable written plan in operation, with procedures to be followed in the event of fire, explosion, or other disaster. The plan is developed and maintained with the assistance of qualified fire, safety, and other appropriate experts, and includes procedures for prompt transfer of casualties and records, instructions regarding the location and use of alarm systems and signals and of fire-fighting equipment, information regarding methods of containing fire, procedures for notification of appropriate persons, and specifications of evacuation routes and procedures. (See 405.1134(a).)	405.1136 Disaster preparedness (a) Standard 1. Some of the specifics of the disaster plan include: a. Assignments of personnel for specific responsibilities; b. Procedures for prompt identification and transfer of patients and records to an appropriate facility and procedures for recording such actions; c. Fire and/or other emergency drills, in accordance with LSC; d. Procedures covering persons in the facility and in the community in case of external disasters, e.g., tornadoes, earthquakes; and e. Arrangements with community resources in the event of disaster. 2. The plan is available to personnel and patients. 3. The specific staff assignments and the evacuation route are posted as appropriate.	405.1136 - Disaster preparedness. (a) Standard 1. The surveyor checks the plan to see that it covers: a. Procedures to be followed; b. Evacuation routes; and c. Assignment of personnel in the event of an internal or external disaster. 2. The administrator is questioned to verify that the plan was developed with the assistance of fire safety and other appropriate experts.

STANDARD	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
(b) Standard: Staff training and drills. All employees are trained, as part of their employment orientation, in all aspects of preparedness for any disaster. The disaster program includes orientation and ongoing training and drills for all personnel in all procedures so that each employee promptly and correctly carries out his specific role in case of a disaster. (See 405.1121(i).)	(b) Standard 1. Orientation of new employees includes review of the overall disaster preparedness plan, training in the use of fire-fighting equipment, activation of fire alarms, and evacuation and transfer procedures. 2. The overall disaster preparedness plan should be rehearsed periodically, preferably as a part of a coordinated drill in which community emergency service agencies participate. 3. A dated written report and evaluation of each drill and rehearsal is maintained.	(b) Standard 1. The surveyor reviews the orientation and staff development program and questions staff to verify that disaster preparedness is included and that personnel know their specific roles. 2. The report of disaster drills is checked to assure that all tours of duty have participated in the drills.

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STANDARD	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
405.1137 Condition of participation--utilization review. The skilled nursing facility carries out utilization review of the services provided in the facility at least to inpatients who are entitled to benefits under the program(s). Utilization review has as its overall objectives both the maintenance of high quality patient care and assurance of appropriate and efficient utilization of facility services. There are two elements to utilization review: medical care evaluation studies that identify and examine patterns of care provided in the facility, and review of extended duration cases which is concerned with efficiency, appropriateness, and cost effectiveness of care.	1. A U.R. Committee is responsible for establishing objectives which assure compliance with the standard. 2. The terms extended duration, continued stay, and extended stay are used interchangeably in the regulations. This review occurs during a patient's stay and consists of a determination of the continued necessity and appropriateness of skilled nursing facility care. 3. The committee may elect to review extended stays of only Federal program beneficiaries or it may review all patients admitted to the facility. Medical Care Evaluation Studies should generally be focused on the care and services provided to all patients, regardless of source of payment.	The surveyor should ascertain that the U.R. committees policies and procedures are directed toward the objectives of utilization review.
(a) Standard: Written plan of utilization review activity. The skilled nursing facility has a currently applicable written description of its utilization review plan. Such description includes: (1) The organization and composition of the committee or group which will be responsible for the utilization review function; (2) Frequency of meetings; (3) The type of records to be kept; (4) The methods and criteria (including norms where available) to be used to define periods of continuous extended duration and to assign or select subsequent dates for continued stay review; (5) Methods for selection and conduct of medical care evaluation studies; (6) The relationship of the utilization review plan to claims administration by a third party; (7) Arrangements for committee reports and their dissemination;	1. Each participating SNF must describe, in writing, its plan for performing review functions. Although standard (a) sets forth requirements for content, it does not mandate facilities to follow any particular model format. For example, a facility may choose to prepare a comprehensive plan document which includes the procedures and criteria related to the review process; or it may prepare a utilization review manual which includes procedures, criteria, a list of committee members, etc. in sections separated from the descriptive plan; or it may choose another alternative. 2. To be acceptable, the written review plan must include the following information: (a) a statement which clearly describes the organization (i.e. committee of the medical staff; medical society committee; other outside group) and composition (i.e. number of physicians and other professional personnel) of the committee;	a) Standard; The surveyor should: 1. review the following documents prior to survey: the UR plan on file, the most recent survey findings, and available information from the intermediary or State Medical Agency where appropriate 2. verify through review of records and reports, and interviews with the UR Chairman and/or members and Administrator that U.R. activities are being performed as described in the plan. Where actual U.R. activities differ from those specified in the plan, the surveyor

STANDARD	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
(8) Responsibilities of the skilled nursing facility's administrative staff.	(b) the frequency of meetings; frequency of meetings will depend upon such variables as the size of the facility, the number of Federal admissions, the scope and number of medical care evaluation (MCE) studies performed and so forth. Considering the requirements for timely review and MCE studies, committees should generally meet at least once each month;	must request a revised plan. The surveyor must forward two (2) copies of the approved revised plan to the Regional Office.
	(c) a description of the types of records and reports to be maintained and mechansims for making them available to appropriate staff and outside agencies;	
	(d) the explicit written criteria developed by the committee and used by reviewers in determining necessity and appropriateness of extended stay;	
	(e) the methods to be used for assigning initial and subsequent dates for extended stay review. Methods must specify whether review dates will be assigned based upon: (1) a specified period of extended stay for all patients not to exceed 30 days from admission or the previous extended stay review date and/or (2) a period specified for each patient using average length of stay data by diagnosis or functional capability in which case the norms used to assist in choosing the extended stay review date must be appended to the plan. See guidelines for Standard (d).	
	(f) The methods to be used in performing medical care evaluation (MCE) studies. Although the UR committee has responsibility to assure the performance of meaningful MCE studies, the actual studies may be performed by a subcommittee or subsidiary committee(s) using other staff in the facility, such as nursing service, consultant professional staff, or persons in charge of medical records. In such instances, the UR committee remains responsible for overall direction of the studies, reviewing study reports and planning and recommending corrective actions.	

STANDARD	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
	(g) The statement referencing relationships with third party payors must provide that the UR plan, procedures, committee minutes and appropriate patient information shall be open to review by fiscal intermediaries, State Agencies and the DHEW, in accordance with applicable laws and regulations.	
	(h) The specific responsibilities of Administrative Staff to support the UR function. See guidelines for Standard (f).	
	(i) Although not required by the regulations, it is strongly suggested that the written UR plan be approved, signed, and dated by appropriate parties (e.g. governing body, Medical Director, Administrator, Chief of Medical Staff).	
(b) Standard: Composition and organization of utilization review committee. (1) The utilization review function is conducted by a staff committee of the skilled nursing facility composed of two or more physicians, with participation of other professional personnel, or by a group outside the facility which is similarly composed and which is established by the local medical or osteopathic society and some or all of the hospitals and skilled nursing facilities in the locality, or by a group established and organized in a manner approved by the Secretary that is capable of performing such function.	(b) Standard: 1. Each SNF must determine how the UR function can most efficiently and effectively be carried out in its facility. It is preferable that the committee be facility based. Where this type of organization is not possible, the preferred alternative is for reviews to be conducted by a group established by the local Medical or Osteopathic Society and some or all of the hospitals and SNFs in the area. In cases where personnel and resources to establish such committees are unavailable another outside group composed of at least two (2) physicians and other professional personnel may be formed, provided the requirements of Standard (b) (3) are met and the committee structure is approved by the Secretary. Regardless of which alternative is chosen, the UR committee must be composed of two or more physician members and include the active participation of non-physician health professionals	(b) Standard: The surveyor: 1. Assists a facility, as requested, in establishing a committee. Where a facility based committee cannot be established, the surveyor should work closely with the facility and other area institutions in establishing a committee sponsored by the local medical or osteopathic society. All efforts made to establish such, committees must be documented. Use of another outside group may be considered only when other efforts have failed.

STANDARD	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
(2) The medical care evaluation studies, as described in paragraph (c) of this section, and education duties of the review program, and the review of admissions and long-stay cases need not be performed by the same committee or group and they need not be performed by a specially established group.	in the review process. The memberships of such health professionals on the URC are encouraged they are, however, excluded from (1) making adverse final judgements regarding the medical necessity for care and (2) giving final approval on the medical criteria used in making admission and extended stay decisions.	
(3) Review by the committee or group may not be conducted by any person who is employed by or who is financially interested in any skilled nursing facility or by any person who was professionally involved in the care of the patient whose case is being reviewed. (N.B. P.L. 93-233 amended Section 1903 (g) of the Act to prohibit review by any person employed by the SNF, eliminating the restriction on persons employed by any SNF. Amended regulations to this effect will appear shortly, and this change is incorporated in the guidelines.)	2. Guidelines interpreting Standard (b)(3) are as follows: a) Employment - Persons other than independent contractors receiving renumeration from an institution for services rendered in that institution other than solely utilization review services shall be considered "employed by the institution"and prohibited from performing utilization review in that same institution or an affiliated institution(s). Persons retained by an institution for the sole purpose of performing utilization review shall be considered eligible to perform such services in that same institution or affiliated institution(s). Persons "employed by one institution" may perform utilization review services for a similar institution providing that the similar institution is in no way affiliated with the institution which is employing the said person for other than review services . An institution is an affiliated institution if it is owned or managed by the same individual(s) or group(s). Excluded from this provision would be hospital employees reviewing care in an affiliated institution or public health employees reviewing care in another publicly owned or managed institution.	2. Verifies that the review function is not performed by personnel who are: employed by the SNF; have financial interest in any SNF; or who are professionally involved in the care of the patient being reviewed. One way to verify employment is to review payroll records. To verify that review decisions are not made by members professionally involved in the patient's care the surveyor should review a sample of medical records of patients reviewed during the past 6 months.

b) "Professionally involved" or "directly responsible" personnel-

Decision making review responsibilities on the medical necessity and appropriateness of services rendered to a patient may not be made by any physician who has issued treatment orders on that patient; or in the case of a non-physician professional, any non-physician who has been directly involved in the formulation and execution of the patient's treatment plan. All physician and non-physician professionals may participate in medical care evaluation studies.

c) Financial interest - Guidelines pending

3. Suggestions for committee organization include:

a. Facility based committees could be formed by physicians who regularly admit (or provide consultation to) patients to the facility, professional consultants (physical therapist, pharmacist), and a public health nurse or staff nurse from a nearby hospital. It must be noted that facility based committees may require a minimum of three (3) physicians to assure availability of two (2) neutral medical opinions prior to any denial of extended stay.

b. The local Medical or Osteopathic Society could establish a regional review committee with a composition of physicians and other health professionals similar to that in Facility based committees. Arrangements could be made for rotation of regular meetings from facility to facility in the region, without necessarily limiting the agenda of each meeting to cases under review in the particular facility where each meeting was

c. Outside groups, where options (a) and (b) are not possible, could be established by the local Health Department, Medical Care Foundation, or the fiscal intermediary who could employ physicians and other health professionals. to perform review. Alternatively, the SNF could make arrangements with a nearby hospital for review to be performed by its UR committee, or by a group of staff physicians and other health professionals. . Where options (a) and (b) are not possible and an outside group is the only alternative open to the facility, the review plan must be written and submitted, through the survey agency, for the Secretary's approval prior to initiation of review. Regardless of the option chosen, committee activities could be facilitated by engaging a non-physician representative to screen patients and assign extended stay dates where committee criteria are met, schedule meetings, monitor the performance of MCE studies and maintain records and reports. Such a non-physician representative need not be a member of the committee. Whether a member or non-member of the committee, non-physician representatives must be properly qualified and trained. Proper qualification and training of such personnel may be left to the discretion of the facility, provided such personnel have reasonable experience in the medical care environment and in using medical terminology, understand the use of screening criteria and meet the requirements of Standard (b)(3).

STANDARD	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
	4. The committee may delegate responsibility for medical care evaluation (MCE) studies to a subcommittee or one or more members of SNF staff. However, the committee retains overall responsibility for the studies and, as noted under standard (a) should generally set priorities for topics to be studied and must analyze all results and assure that appropriate actions are taken to correct problems where found.	
(c) Standard: Medical care evaluation studies. Medical care evaluation studies are performed to promote the most effective and efficient use of available health facilities and services consistent with patient needs and professionally recognized standards of health care. Studies emphasize identification and analysis of patterns of patient care, and suggest, where appropriate, possible changes for maintaining consistently high quality patient care and effective and efficient use of services. Each medical care evaluation study (whether medical or administrative in emphasis) identifies and analyzes factors related to the patient care rendered in the facility, and where indicated, results in recommendations for change beneficial to patients, staff, the facility and the community. Studies on a sample or other basis include, but need not be limited to: admissions, durations of stay, ancillary services furnished (including drugs and biologicals), and professional services performed on facility premises. At least one study must be in progress at any given time, and at least one study must be completed each year. The study will be accomplished by considering and analyzing data obtained from any one or a combination of the following sources: (1) Medical records or other appropriate data; (2) External organizations which compile statistics, design profiles, and produce other comparative data; and	(c) Standard: 1. Medical care evaluation (MCE) studies are specifically designed in-depth studies focusing on potential or actual problem areas of health care practice. They are usually performed through retrospective review of patient records, though some data may be collected during patient stays. They may address a wide variety of topics, including health care processes and outcomes as well as aspects of the organization and delivery of health care. For the most part, studies relate to patterns of care provided by groups of health professionals to groups of patients, and do not focus on individuals. Results of studies are used to initiate educational programs which are designed to remedy problems in the practice of health care identified by the studies, or may lead to recommendations for change in the administration and delivery of health care. 2. While most studies will scrutinize patterns of admissions, durations of stay, and provision of ancillary and professional services, a wide variety of topics may be chosen based on potential problem areas perceived by accumulation of data and experience from screening of extended stay cases and on the consensus of the professional staff.	(c) Standard: 1. The minutes of the utilization review committee are checked to verify that the findings of the studies are reported to the committee and that the committee makes recommendations to the staff and administration for corrective actions. 2. By review of the minutes or interview, the surveyor verifies that at least one study is in progress and at least one study has been completed during the preceeding 12 mos. In the case of surveys done prior to 7/1/76 surveyor need only verify that one study is in progress.

STANDARD	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
(3) By cooperative endeavor with the PSRO, fiscal intermediary(ies), providers of services, or appropriate agencies.	3. Where appropriate, the requirement for MCE study activity in each institution may be met by participation in studies performed in cooperation with other facilities with similar health care problems. These cooperative studies may be organized by the institutions themselves, the PSRO, the fiscal agent or other regional agency. 4. In addition to the patient record or other in-house sources such as nursing notes or medicine Kardex, data may be collected from an external organization, where appropriate, such as abstracting services, the PSRO, fiscal agent or other agencies where they provide useful data.	
The committee or group shall document the results of each medical care evaluation study and how such results have, where appropriate, been used to institute changes to improve the quality of care and promote more effective and efficient use of facilities and services.	5. The committee must keep written records of study findings, the analysis of the findings, the recommendations made as a result of the analysis, the actions resulting from the recommendations, and the effectiveness of the actions in correcting problem areas. A follow-up of the original topic at a reasonable time after completion of corrective actions may be a useful way to document change resulting from the actions.	

STANDARD	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
(d) Standard: Extended stay review. (1) Periodic review is made of each current inpatient skilled nursing facility beneficiary case of continuous extended duation, the length of which is defined in the utilization review plan, to determine whether further inpatient stay is necessary. The plan may specify a different number of days for different diagnostic classes of cases, or may use the same number of days for all cases. In any event the period(s) specified bears a reasonable relationships to current average length-of-stay statistics and does not exceed 30 days after admission. An exception to this 30-day limit may be made where the extended stay review date is based on: (i) The average, or some other appropriate point (e.g., median) of current length of stay data for diagnostic classes of cases selected by the committee or group in accordance with guidelines established by the Secretary, when the average (or other length of stay review point) for the individual's specific diagnostic class or category, based on functional capability exceeds 30 days; or (ii) A period, established pursuant to section 1814(h)(1) of the Act, which exceeds 30 days.	(d) Standard: 1. The UR plan specifies the number of continuous days of skilled nursing facility stay following which review is made to determine the medical necessity and appropriateness of extended stay beyond the number of continuous days assigned. The date of such extended stay review is assigned to each patient by a physician or nonphysician reviewer at the time of admission or at the time a patient in the facility becomes eligible for Title XVIII or Title XIX reimbursement. The date of extended stay review should be attached to the patient's record so that all involved parties will have knowledge of the date. 2. The date of extended stay review assigned at the time of admission or occurence of eligibility may be selected on the basis of: (a) A specified period of time not to exceed 30 days, or (b) A period of time specific for each patient taking into consideration his diagnosis and functional capability. After establishing a patient's diagnosis or functional capability, statistical tables should be consulted to assist in selecting an appropriate extended stay review date. (A sample of such tables is attached to these guidelines). Most available tables list current average length of stay data for SNF patients by primary diagnosis. For each patient admitted, the patient's primary diagnosis should be found on the table and the average or median length of stay for patients with that	(d) Standard: 1. The surveyor reviews the facility's definition of extended stay in the utilization review plan and verifies that the committee is reviewing cases of extended stay on or before the expiration of the stated period and at the specified interval stated in the facility's UR plan. 2. If the committee uses a different number of days for different diagnoses or functional categories for the period of extended stay, the surveyor verifies that there is a written list with the lengths of stay designated for each diagnosis of functional category. 3. If a non-physician representative is performing the review functions, the non-physician representativ has experience in screening cases for further review of has had training in application of screening criteria.

STANDARD	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
(2) The initial extended stay review takes place prior to or at the end of period of extended duration specified pursuant to paragraph (d)(1) of this section. The review is based on the attending physician's reasons for and plan for continued stay and any other documentation the committee or group deems appropriate. Cases may be screened by a qualified nonphysician representative of the committee or group who uses criteria established by the physician members of the committee, provided that cases are referred to a physician member for further review when it appears that the patient no longer requires further inpatient care. Where the committee or group selects a nonphysician representative to screen extended stay review cases, it will select an individual with experience in such screening or appropriate training in the application of the screening criteria used, or both. The Secretary may grant an additional period of time, beyond July 1, 1975 the effective date of this paragraph, for a committee or group of a skilled nursing facility to select or develop the written criteria and standards required by this paragraph. (i) Where the committee or group documents that it made every effort to comply by July 1, 1975 and that is currently making substantial progress in developing the criteria and standards; and (ii) where the committee or group establishes a timetable for meeting the requirements which is acceptable to the Secretary. N.B. July 1, 1975 implementation date reflects amendment to regulations published in the April 1, 1975 Federal Register.)	diagnosis should be read from the table and assigned as the period defining the date of extended stay review. Either the average or median length of stay may be appropriately chosen. (The median length of stay is the same as the 50th percentile of lengths of stay on the tables; it is the day by which 50% of patients with each particular primary diagnosis will have left the facility.) (c) A period established pursuant to Section 1814 (h)(i) of the Act. Regulations applicable to this section will be published at a later date, and until then this provision should be regarded as inoperative. 3. Extended stay review for each patient must occur on or before the date assigned. Review may be conducted by the UR committee or group, a subgroup of the committee or group, or a qualified representative of the committee or group. The review is based primarily on information provided in the patient's record by the attending physician , (i.e. the attending physician's reasons for extending the patient's stay and his plan for further care), and may include other available information reflecting the condition of the patient.	4. The surveyor should check written criteria and the review process to: a. Verify that physician members of the committee have established the criteria; and b. Ascertain whether the criteria are being used by physician reviewers and non-physician representatives in the initial screening proces

STANDARD	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
(3) Where a finding is made that the individual continues to need inpatient skilled nursing care, an additional stay is approved for a period the committee or group deems appropriate, provided that reviews are made at least every 30 days for the first 90 days and at least every 90 days thereafter. Before the expiration of each new period, the case must be reviewed again in like manner, sith such reviews being repeated as long as the stay continues beyond the scheduled review dates and notice has not been given pursuant to paragraph (e) of this section.	4. When qualified non-physician representatives perform review, such persons must have had experience in a medical care environment, in the use of medical terminology and must understand the use and application of screening criteria, as well as meet the requirements of Standard(b)(3). If such a qualified non-physician representative performs extended stay review, written criteria must be used to screen out those cases which need further review by the committee or group. When physician reviewers perform the initial screening function, written criteria must also be used, as review may be conducted more efficiently and with more uniformity and less bias if written criteria are used as tools to guide the review process. Such written criteria may be criteria reflecting the patient's need for the services available at the skilled nursing facility level of care, or may be criteria reflecting the necessity and appropriateness of continued care of patients with a particular diagnosis or problem in the skilled nursing facility (see example of level-of-care criteria attached.) Where patient categories are identified which the group or committee's experience indicates are associated with high costs, frequent furnishing of excessive services or are attended by physicians whose patterns of care are frequently found to be questionable, more intensive review methods should be applied. More intensive review may be conducted by application of more detailed written criteria, by automatic referral of patients in these potential problem categories to one or more physician reviewers, by subjecting such patient categories to the scrutiny of medical care evaluation studies, or by other methods chosen by the committee.	

Written criteria used for review must be established and approved by the physician members of the committee, with participation of the UR committee as a whole where appropriate. The physician members may make use of appropriate medical specialists for assistance in establishing criteria where necessary, or may adopt or adapt model criteria available from specialty societies, medical societies or foundations, PSROs, DHEW or other sources.

5. When the extended stay reviewer finds that a patient continues to need skilled nursing facility care, an additional stay is approved for a period of time deemed appropriate by the committee or group in accordance with the UR plan. Such periods of time may be based on either a standard number of days or on each particular patient's condition using available length-of-stay data for patients with similar conditions. Repeat extended stay review will be made at the end of the assigned extension of stay, and at the end of each subsequent extension of stay found to be medically necessary and appropriate by the committee or group.

The second extended stay review must occur no more than 30 days after the first extended stay review date and the third extended stay review must occur no more than 30 days after the second except where review dates based on diagnostic or functional categories are used. Extended stay reviews beyond the 90th day after admission must occur at intervals of no more than 90 days.

STANDARD

(e) Standard : Admission or further stay not medically necessary. (1) A final determination of the committee or group that an admission or continued stay is not medically necessary is made by at least two physician members of the committee or group, except that the final determination may be made by one physician member where the attending physician, when given an opportunity to express his views, does not do so, or does not contest the finding that the admission or continued stay is not medically necessary. (See a 405.166 regarding the restriction on payment after an adverse decision by the committee or group).

(2) If the committee or group, or its nonphysician representative where a physician member concurs, has reason to believe from the review of an admission or an extended duration case or a case reviewed as part of a medical care evaluation study that further stay is no longer medically necessary (or that admissions were not medically necessary), the committee or group shall notify the individual's attending physician and afford him an opportunity to present his views before it makes a final determination. If the final determination of the committee or group is that further stay is no longer medically necessary, written notification of the finding is given to the facility, the attending physician, and the individual (or where appropriate, his next of kin) no later than two days after such final determination is made and, in no event in the case of an extended duration case, later than 3 working days after the end of the extended duration period specified pursuant to paragraph (d) of this section.

INTERPRETIVE GUIDELINES

(e) Standard :

1. When a non-physician representative makes an initial finding that the written criteria for extended stay are not met, the case must be referred to the committee, or a sub-group thereof which contains at least one physician. If the committee or subgroup agrees after reviewing the case that extended stay is not medically necessary or appropriate, the attending physician is notified and allowed an opportunity to present his views and any additional information relating to the patient's needs for extended stay. When a physician member of the committee performs the initial review instead of a non-physician reviewer, and he finds that extended stay is not necessary, no referral to the committee or subgroup is necessary and he may notify the attending physician directly.

2. If the attending physician does not respond or does not contest the findings of the committee or subgroup or those of the physician who performed the initial review, then the findings are final. Written notification of this final determination must be sent to the attending physician, the patient (or next of kin), the facility administrator and the single State agency (in the case of Medicaid) no later than two days after such final determination and in no event later than three working days after the end of the assigned extended stay period.

   Where possible, the written notification should be received by all involved parties within the stated time period. Where appropriate and desired, verbal notification may precede written notification.

3. If the attending physician contests the findings of the committee or subgroup, or those of the physician who performed the initial review, or if he presents additional information relating to the patient's need for extended stay, at least one additional physician member of the committee must review the case. If the two physician members determine that the patient's stay is not medically necessary or appropriate after considering all the evidence, their determination becomes final. Written notification of this decision must be sent to the attending physician, patient (or next of kin), facility administrator, and

SURVEY PROCEDURES

(e) Standard :

The Surveyor verifies through the review of the minutes and other documentation that:

1. The need for extended stay is reviewed as set forth by the plan;

2. All final decisions that further stay is not medically necessary are made by physician member(s) of the committee;

3. Written notification of denial is sent to all concerned within the specified timeframes.

the single State agency (in the case of Medicaid) no later than two days after such final decision and in no event later than three working days after the end of the assigned extended stay period.

4. In no case may a non-physician make a final determination that a patient's stay is not medically necessary or appropriate.

5. If, after referral of a questioned case to the committee or subgroup thereof, the physician reviewer(s) determine that extended stay is justified, the attending physician shall be so notified and an appropriate date for subsequent extended stay review will be selected and noted on the patient's record.

6. A working day is defined by the Department as including at least Monday through Friday, or any other five days of each week at the option of the institution, excluding holidays observed by the institution.

The committee responsible for utilization review in each institution should subject non-working day activities to close professional scrutiny through appropriate medical care evaluation studies and other retrospective methods to identify any possible unusual patterns of practice which may occur on those days. Correction of any problems in utilization or quality of care provided on non-working days should be made through appropriate educational or administrative initiatives recommended by the committee.

STANDARD	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
(f) Standard: Administrative responsibilities. The administrative staff of the facility is kept directly and fully informed of committee activities to facilitate support and assistance. The administrator studies and acts upon recommendations made by the committee, coordinating such functions with appropriate staff members.	(f) Standard: The administrator, preferably with assistance from the Medical Director, has responsibility for assuring the availability of physicians and non-physicians for performing UR functions, and for assisting and supporting the committee in establishing a plan. Specific administrative functions related to UR committee activities include: (1) providing assistance (clerical and/or professional staff) in preparing necessary information on new admissions to assure assignment of an initial extended stay review date; (2) identifying and making available the medical records or abstracts thereof, of patients requiring extended stay review; (3) assuring availability to the UR committee of discharge planning information, including available community resources for alternatives to skilled nursing care; (4) assisting the committee in the conduct of medical care evaluation studies; (5) where appropriate, acting upon the recommendations made by the UR committee subsequent to extended stay review findings and/or MCE studies; (6) preparing and distributing all pertinent records and reports relating to UR findings and decisions. For example, preparation and distribution of notices where extended stay is found to be no longer medically necessary; reports for State Agencies and intermediaries.	(f) Standard: The Surveyor should: 1. review the requirements of the standard with the Administrator and ascertain how they are being met; 2. ascertain that the Administration is supportive of UR both in terms of direct assistance provided and follow-up on actions recommended by the committee; 3. ascertain through interviews with the Director, etc. that all records and reports are disseminated in accordance with the plan. 4. ascertain the availability of community resource material, of discharge forms, etc. which facilitate the process of discharge planning.

STANDARD

(g) Standard: Utilization review records. Written records of committee activities are maintained. Appropriate reports, signed by the committee chairman, are made regularly to the medical staff, administrative staff, governing body, and sponsors (if any). Minutes of each committee meeting are maintained and include at least:

(1) Name of committee,

(2) Date and duration of meeting,

(3) Names of committee members present and absent,

(4) Description of activities presently in progress to satisfy the requirements for medical care evaluation studies, including the subject and reason for study, dates of commencement and expected completion, summary of studies completed since the last meeting, conclusions, and follow-up on implementation of recommendations made from previous studies, and

(5) Summary of extended duration cases reviewed, including the number of cases, case identification numbers, admission and review dates, and decisions reached, including the basis for each determination and action taken for each case not approved for extended care.

INTERPRETIVE GUIDELINES

(g) Standard:

Since there are a number of recording requirements to be fullfilled, administrators of SNFs should be encouraged to assign clerical and other assistants to the UR committee, thus freeing the time of professional members to attend to review and related activities.

The committee will need to develop methods for recording:

(1) Review determinations on each patient

The committee may wish to develop or select a patient abstract or review summary form for recording all actions taken during the review process. The form would include patient identification data; physician identification data; diagnosis(es), problem(s), or functional capability; date of admission; data of initial extended stay review; date(s) of subsequent reviews; and decisions made on extended stay review(s). Where the reviewer questions the need for extended stay, the form would document contact or attempted contact with the attending physician. It would also document the decisions, including the basis for the decision of two physicians where the final decision is to deny extended stay.

Use of an abstract or summary form would facilitate the review process and would provide data for review by the whole committee at its regular meeting. Individual abstract forms can be appended to the committee minutes, or actions taken on all patients reviewed during the month can be summarized in the minutes. Such forms can also provide the URC committee with data which can be analyzed for purposes of modifying criteria, developing length of stay norms or selecting MCE study topics.

Patient identification portions of the Form could be completed by appropriate supporting staff, and review information portions could be completed and signed by the reviewer(s).

SURVEY PROCEDURES

(g) Standard

1. review the minutes of the UR committee to verify that they include:

   a. date of meeting;
   b. names and titles of members in attendance or absent;
   c. number of extended stay reviews approved and disapproved since the last meeting with reasons for all disapprovals.
   d. status report on any MCE studies underway including description of findings of completed studies, and action taken;

2. all records and reports including any patient abstract or review summary form, must be retained for the period of time required by State law. Where there is no applicable State statute, records and reports must be retained for 5 years from the date of discharge; or in the case of a minor, 3 years after the patient becomes of age under State law.

(2) Medical Care Evaluation Study summaries and status reports

A status report of each study under way should be presented to the committee at each meeting. Discussion will be included in the minutes. When a study has been completed, the summary may be appended to the minutes as may any memoranda setting forth recommendations for educational programs or for changes in policies, procedures, etc. Other discussion pertaining to the study should be included in the committee minutes.

(3) Other committee records and reports

The minutes or appropriate appendices should include, as appropriate, the actions taken with respect to: criteria selection or modification; the use of length of stay norms; requests by physicians for reconsideration of UR committee decisions; follow-up of MCE study findings and recommendations; and other committee activities.

The committee should determine the best method(s) for disseminating minutes and reports to appropriate professional, administrative and governing body personnel within each facility.

STANDARD	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
(h) Standard: Discharge planning. The facility maintains a centralized, coordinated program to ensure that each patient has a planned program of continuing care which meets his postdischarge needs.	(h) Standard;	(h) Standard:
(1) The facility has in operation an organized discharge planning program. The utilization review committee, in its evaluation of the current status of each extended duration case, has available to it the results of such discharge planning and information on alternative available community resources to which the patient may be referred.	1. The primary goal of a discharge planning program is to provide comprehensive and continuous care to patients. The program should be structured to encourage patient and family participation in setting treatment goals and establishing a long range plan of care. Each patient must have an individualized discharge plan which reflects input from all disciplines involved in his care. The plan must be accurate, realistic and current to provide for uninterrupted care and services as the patient moves from one environment to another.	(1) The surveyor ascertains that the facility has established an efficient discharge planning program.
(2) The administrator delegates responsibility for discharge planning, in writing, to one or more members of the facility's staff, with consultation, if necessary, or arranges for this service to be provided by a health, social, or welfare agency (See 405.1121(i).	2. Discharge planning includes preparing the patient for the next level of care and arranging for appropriate placement (i.e. home, ICF, hospital, etc.) Information needed for the discharge planning process includes: prior health status of the patient; diagnosis; functional status; medical orders; therapy(ies) and teaching needs; current level of care needed; projected time frame for moving patient to next level of care; community resources available; and procedures for initiating and effecting transfer to other levels of care. To ensure optimal benefits, discharge planning must be a coordinated effort among the facility, the patient and his family, and the resource to which the patient may be discharged.	(2). The surveyor reviews the policies and procedures to verify that they contain the following: a. Functions of the discharge planning coordinator in evaluating the patient's condition to determine potential needs, in providing continuity of care, and in recording the results of such an evaluation; b. Participation in the evaluation and planning by representatives from the pertinent disciplines; c. A statement of the time period by which each patient must be evaluated in terms of discharge planning; and a statement of the time period in which each patient must be reevaluated; d. A provision for making information available to the UR committee e. A listing of local resources available; f. Provision for a discharge summary on each patient; g. Provisions for review and reevaluation of the discharge planning program.
(3) The facility maintains written discharge planning procedures which describe (i) how the discharge coordinator will function, and his authority and relationships with the facility's staff; (ii) the time period in which each patient's need for discharge planning is determined (preferably within 7 days after the day of admission); (iii) the maximum time period after which a reevaluation of each patient's discharge plan is made; (iv) local resources available to the facility, the patient, and the attending physician to assist in developing and implementing individual discharge plans; and (v) provisions for periodic review and re-evaluation of the facility's discharge planning program.	3. The administrator is responsible for organizing the facility's discharge planning program. It is preferable that the program be facility based and coordinated by a staff member who gives full or part time to the function, depending upon the needs for this service. If the facility is unable to designate a responsible staff person, arrangements can be made with an outside resource.	

STANDARD	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
(4) At the time of discharge, the facility provides those responsible for the patient's postdischarge care with an appropriate summary of information about the discharged patient to ensure the optimal continuity of care. The discharge summary includes at least current information relative to diagnoses, rehabilitation potential, a summary of the course of prior treatment, physician orders for the immediate care of the patient, and pertinent social information.	Where an outside resource is used, there should be a memorandum of agreement developed which describes the responsibilities of the two parties in developing and carrying out explicit discharge planning procedures. 4. Each SNF must develop a written plan which describes its discharge planning program. The plan must include: (1) the person(s) or agency to be responsible for the function; (2) a job description for the coordinator detailing his authority, staff relationships, duties and functions, and educational or experiential requirements; (3) explicit procedures for performing the function including all forms to be used for formulation of the plan, making referrals, and preparing discharge summaries; (4) a compilation of local resources (e.g., private and public Health-Welfare Agencies, Hospitals, ICF's, licensed room and board facilities meals on wheels, home health agencies); (5) procedures for coordinating activities with the U.R. Committee and any other appropriate committee (e.g., patient care policies committee); and, (6) a provision for at least annual review of the plan by appropriate parties. Discharge planning procedures should include provisions for at least the following: (a) Referral of cases to the discharge planning coordinator; (b) Identifying and evaluating the patients functional status and medical, nursing, rehabilitation and other needs. This will generally be accomplished through review of the record, individual interviews, and team conferences; (c) Developing a discharge plan for each patient which reflects input from all disciplines, as appropriate. Examples of participation include:	(3) By examination of a sampling of medical records (current and discharged patients), the surveyor verifies that the policies and procedures are being followed.

(1) physician - determines overall treatment plan; probable length of stay, the next level of care anticipated; and orders care and services needed;

(2) dietitian - provides teaching and consultation to patient and/or family; provides sample diets where appropriate;

(3) pharmacist - prepares the drug profile to accompany the patient and instructs the patient and/or family in the administration of drugs, where appropriate;

(4) nurse - assesses the patients nursing and health needs and provides information about these needs; provides appropriate instruction to patients and/or family;

(5) therapists - develops treatmjent plan in tandem with physician; teaches patient and family; informs coordinator of sources for procuring equipment and supplies.

(d) Multi-disciplinary team conferences

(e) Initiating referrals

(f) Maintaining liaison with the UR committee

(g) Orienting staff personnel to discharge planning and referral procedures and providing periodic in-service training sessions;

(h) Preparing comprehensive patient care summaries for transmittal with the patient upon discharge to assure continuity of care; use of a discharge summary form is encouraged. The form must capture at least

STANDARD	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
	the following items: identifying information (e.g., name, address, D.O.B., Medicare number, Medicaid number); next of kin or sponsor; final diagnosis; medication and treatment orders; appropriate laboratory and X-ray reports; functional capacity; special instructions (e.g., patient cannot smoke unattended); level of care needs; and summary of overall plan of care developed by multicisciplinary teams under 4(c) above.	(i) Standard: Survey agency responsibilities for surveying facilities where a PSRO performs review will be described in the near future.
(i) Standard: Applicability of utilization review requirements approved under Title XIX. Notwithstanding the preceding paragraphs of this section, if the Secretary determines that the utilization review procedures established by a State pursuant to Title XIX of the Social Security Act are superior in their effectiveness to the procedures required under this section, any provision of the State plan for which the waiver of the requirements set forth in this section for utilization review in skilled nursing facilities is granted shall, to the extent deemed appropriate by the Secretary, be utilized by skilled nursing facilities in that State, instead of the procedures specified in this section.	(i) Standard: A number of States have filed waiver applications with the Secretary. Where the State system with respect to review of Title XIX SNF beneficiaries is determined to be superior to the Title XVIII UR system, an interim waiver will be granted for a 12-24 month period. Pending such a determination by the Secretary, states may continue to use their Title XIX systems where they are already functioning. During the interim 12-24 month waiver period, Title XVIII beneficiaries will be reviewed under the November 29, 1974, Title XVIII regulations in any State granted a Title XIX waiver. Title XIX patients covered by the waiver will be reviewed according to the Title XIX waivered system. Where a final Title XIX waiver is granted to a State after the 12-24 month interim period, the Secretary will ascertain the applicability of the waivered system to Title XVIII beneficiaries. Any plan to apply the State-waivered system to Title XVIII beneficiaries will be published as a notice of proposed rule making and will not be effective until final rules are published in the Federal Register. Where a conditional PSRO is performing review in a SNF under memoranda of understanding with the facility, Title XVIII intermediary and Title XIX single State agency, the PSRO decisions shall be binding. PSRO review in a SNF superseded UR regulatory requirements.	

Definitions of Terms Used in Conditions of Participation for Skilled Nursing Facilities

405.1101

(a) Administrator of skilled nursing facility. A person who:

(1) Is licensed as required by State law; or

(2) If the State does not have a Medicaid program, and has no licensure requirement, is a high school graduate (or equivalent), has completed courses in administration or management approved by the appropriate State agency, and has 3 years of supervisory management experience in a skilled nursing facility or related health program; or

(3) If the administrator of a hospital in which there is a hospital-based distinct-part skilled nursing facility, in a State that does not license skilled nursing facility administrators, meets the requirements of § 405.1021(f).

(b) Approved drugs and biologicals. Only such drugs and biologicals as are:

(1) In the case of Medicare;

(i) Included (or approved for inclusion) in the United States Pharmacopoeia, National Formulary, or United States Homeopathic Pharmacopoeia; or

(ii) Included (or approved for inclusion) in AMA Drug Evaluations or Accepted Dental Therapeutics, except for any drugs and biologicals unfavorably evaluated therein; or

(iii) Not included (nor approved for inclusion) in the compendia listed in paragraphs (b)(1)(i) and (b)(1)(ii) of this section, may be considered approved if such drugs:

(A) Were furnished to the patient during his prior hospitalization, and

(B) Were approved for use during a prior hospitalization by the hospital's pharmacy and drug therapeutics committee (or equivalent), and

(C) Are required for the continuing treatment of the patient in the facility.

(2) In the case of Medicaid, those drugs approved by the State Title XIX agency.

(c) Charge nurse. A person who is:

(1) Licensed by the State in which practicing as a:

(i) Registered nurse; or

(ii) Practical (vocational) nurse who:

(A) Is a graduate of a State-approved school of practical (vocational) nursing; or

(B) Has 2 years of appropriate experience following licensure by waiver as a practical (vocational) nurse, and has achieved a satisfactory grade on a proficiency examination approved by the Secretary, or on a State licensure examination which the Secretary finds at least equivalent to the proficiency examination, except that such determinations of proficiency shall not apply with respect to persons initially licensed by a State or seeking initial qualifications as a practical (vocational) nurse after December 31, 1977; and

(2) Is experienced in nursing service administration and supervision and, in areas such as rehabilitative or geriatric nursing, or acquires such preparation through formal staff development programs.

In the case of skilled nursing facility services in an institution for the mentally retarded or in an institution for those with mental diseases, or a distinct part thereof, a person licensed in another category of health care discipline who has special training in the care of such patients may serve as charge nurse provided that such person is licensed in such category by the State following completion of a course of training which included at least the number of classroom and practice hours in all the nursing subjects included in the program of a State-approved school of practical (vocational) nursing, as evidenced by a report on comparison of the courses in the respective curricula to the State agency by the agency(ies) of the State responsible for the licensure of such personnel. (An institution primarily engaged in the care of the mentally retarded or in the treatment of mental diseases cannot qualify as a participating skilled nursing facility under Medicare.)

(d) Controlled drugs. Drugs listed as being subject to the Comprehensive Drug Abuse Prevention and Control Act of 1970 (Pub. L. 91-513) as set forth in 21 CFR Part 308.

(e) Dietetic service supervisor. A person who:

(1) Is a qualified dietitian; or

(2) Is a graduate of a dietetic technician or dietetic assistant training program, corresponding or classroom, approved by the American Dietetic Association; or

(3) Is a graduate of a State-approved course that provided 90 or more hours of classroom instruction in food service supervision and has experience as a supervisor in a health care institution with consultation from a dietitian; or

(4) Has training and experience in food service supervision and management in a military service equivalent in content to the program in paragraph (e)(2) or (e)(3) of this section.

(f) Dietitian (qualified consultant). A person who:

(1) Is eligible for registration by the American Dietetic Association under its requirements in effect on January 17, 1974; or

(2) Has a baccalaureate degree with major studies in food and nutrition, dietetics, or food service management, has 1 year of supervisory experience in the dietetic service of a health care institution, and participates annually in continuing dietetic education.

(g) Director of nursing services. A registered nurse who is licensed by the State in which practicing, and has 1 year of additional education or experience in nursing service administration, as well as additional education or experience in such areas as rehabilitative or geriatric nursing, and participates annually in continuing nursing education.

(h) Drug administration. An act in which a single dose of a prescribed drug or biological is given to a patient by an authorized person in accordance with all laws and regulations governing such acts. The complete act of administration entails removing an individual dose from a previously dispensed, properly labeled container (including a unit dose container), verifying it with the physician's orders, giving the individual dose to the proper patient, and promptly recording the time and dose given.

(i) Drug dispensing. An act entailing the interpretation of an order for a drug or biological and, pursuant to that order, the proper selection, measuring, labeling, packaging, and issuance of the drug or biological for a patient or for a service unit of the facility.

(j) Existing buildings. For purposes of ANSI Standard No. A117.1 and minimum patient room size (see § 405.1134(c) and (e) in skilled nursing facilities or parts thereof whose construction plans are approved and stamped by the appropriate State agency responsible therefore before the date these regulations become effective.

(k) Licensed nursing personnel. Registered nurses or practical (vocational) nurses licensed by the State in which practicing.

(l) Medical record practitioner (qualified consultant). A person who:

(1) Is eligible for certification as a registered record administrator (RRA), or an accredited record technician (ART), by the American Medical Record Association under its requirements in effect on the publication of this provision; or

(2) Is a graduate of a school of medical record science that is accredited jointly by the Council on Medical Education of the American Medical Association and the American Medical Record Association.

(m) Occupational therapist (qualified consultant). A person who:

(1) Is a graduate of an occupational therapy curriculum accredited jointly by the Council on Medical Education of the American Medical Association and the American Occupational Therapy Association; or

(2) Is eligible for certification by the American Occupational Therapy Association under its requirements in effect on the publication of this provision; or

(3) Has 2 years of appropriate experience as an occupational therapist, and has achieved a satisfactory grade on a proficiency examination approved by the Secretary, except that such determinations of proficiency shall not apply with respect to persons initially licensed by a State or seeking initial qualifications as an occupational therapist after December 31, 1977.

(n) Occupational therapy assistant. A person who:

(1) Is eligible for certification as a certified occupational therapy assistant (COTA) by the American Occupational Therapy Association under its requirements in effect on the publication of this provision; or

(2) Has 2 years of appropriate experience as an occupational therapy assistant, and has achieved a satisfactory grade on a proficiency examination approved by the Secretary, except that such determination of proficiency shall not apply with respect to persons initially licensed by a State or seeking initial qualification as an occupational therapy assistant after December 31, 1977.

(o) Patient activities coordinator (qualified consultant). A person who:

(1) Is a qualified therapeutic recreation specialist; or

(2) Has 2 years of experience in a social or recreational program within the last 5 years, 1 year of which was full-time in a patient activities program in a health care setting; or

(3) Is a qualified occupational therapist or occupational therapy assistant.

(p) Pharmacist. A person who:

(1) Is licensed as a pharmacist by the State in which practicing, and

(2) Has training or experience in the specialized functions of institutional pharmacy, such as residencies in hospital pharmacy, seminars on institutional pharmacy, and related training programs.

(q) Physical therapist (qualified consultant): A person who is licensed as a physical therapist by the State in which practicing, and

(1) Has graduated from a physical therapy curriculum approved by the American Physical Therapy Association, or by the Council on Medical Education and Hospitals of the American Medical Association, or jointly by the Council on Medical Education of the American Medical Association and the American Physical Therapy Association; or

(2) Prior to January 1, 1966, was admitted to membership by the American Physical Therapy Association, or was admitted to registration by the American Registry of Physical Therapists, or has graduated from a physical therapy curriculum in a 4-year college or university approved by a State department of education; or

(3) Has 2 years of appropriate experience as a physical therapist, and has achieved a satisfactory grade on a proficiency examination approved by the Secretary, except that such determinations of proficiency shall not apply with respect to persons initially licensed by a State or seeking qualification as a physical therapist after December 31, 1977; or

(4) Was licensed or registered prior to January 1, 1966, and prior to January 1, 1970, had 15 years of full-time experience in the treatment of illness or injury through the practice of physical therapy in which services were rendered under the order and direction of attending and referring physicians; or

(5) If trained outside the United States, was graduated since 1928 from a physical therapy curriculum approved in the country in which the curriculum was located and in which there is a member organization of the World Confederation for Physical Therapy, meets the requirements for membership in a member organization of the World Confederation for Physical Therapy, has 1 year of experience under the supervision of an active member of the American Physical Therapy Association, and has successfully completed a qualifying examination as prescribed by the American Physical Therapy Association.

(r) Physical therapist assistant. A person who is licensed as a physical therapist assistant, if applicable, by the State in which practicing, and

(1) Has graduated from a 2-year college-level program approved by the American Physical Therapy Association; or

(2) Has 2 years of appropriate experience as a physical therapist assistant, and has achieved a satisfactory grade on a proficiency examination approved by the Secretary, except that such determinations of proficiency shall not apply with respect to persons initially licensed by a State or seeking initial qualification as a physical therapist assistant after December 31, 1977.

(s) Social worker (qualified consultant). A person who is licensed, if applicable, by the State in which practicing, is a graduate of a school of social work accredited or approved by the Council on Social Work Education, and has 1 year of social work experience in a health care setting.

(t) Speech pathologist or audiologist (qualified consultant). A person who is licensed, if applicable, by the State in which practicing, and

(1) Is eligible for a certificate of clinical competence in the appropriate area (speech pathology or audiology) granted by the American Speech and Hearing Association under its requirements in effect on the publication of this provision; or

(2) Meets the educational requirements for certification, and is in the process of accumulating the supervised experience required for certification.

(u) Supervision. Authoritative procedural guidance by a qualified person for the accomplishment of a function or activity within his sphere of competence, with initial direction and periodic inspection of the actual act of accomplishing the function or activity. Unless otherwise stated in regulations, the supervisor must be on the premises if the person does not meet assistant-level qualifications specified in these definitions.

(v) Therapeutic recreation specialist (qualified consultant). A person who is licensed or registered, if applicable, by the State in which practicing, and is eligible for registration as a therapeutic recreation specialist by the National Therapeutic Recreation Society (Branch of National Recreation and Park Association) under its requirements in effect on publication of this provision.

STANDARD

405.1911 Special waivers applicable to skilled nursing facilities.

(a) Waiver of 7-day registered nurse requirement. To the extent that 405.1124 requires any skilled nursing facility to engage the services of a registered nurse more than 40 hours a week, the Secretary may waive such requirement for such periods as he deems appropriate if, based upon documented findings of the State agency, he determines that:

(1) Such facility is located in a rural area and the supply of skilled nursing facility services in such area is not sufficient to meet the needs of individual patients therein,

(2) Such facility has at least one full-time registered nurse who is regularly on duty at such facility 40 hours a week, and

(3) Such facility (i) has only patients whose attending physicians have indicated (through physicians' orders or admission notes) that each such patient does not require the services of a registered nurse for a 48-hour period, or (ii) has made arrangements for a registered nurse or a physician to spend such time at the facility as is determined necessary by the patient's attending physician to provide necessary services on days when the regular full-time registered nurse is not on duty.

INTERPRETIVE GUIDELINES

The 7-day registered nurse coverage requirement may be waived if all of the following conditions are present:

1. The facility has at least one registered nurse present on the premises to render or supervise the nursing services 40 hours per week and there are licensed practical (vocational) nurses on all other tours of duty 7 days a week.

2. The facility is located in a rural area and there are no other facilities available within 60 minutes driving time to provide such services. In deciding whether the denial of a provider would seriously limit beneficiary access to services, the following factors should be considered:

   a. Location of other providers, in terms of topography of the surrounding community, e.g., mountainous terrain, the absence of safe, efficient, and regularly available transportation, and the existing medical care pattern;

   b. Existing bed shortage in the community. The existence of bed shortages is determined by reference to the occupancy rates and waiting lists in the participating skilled nursing facilities; and

   c. Evidence of good faith on the part of the provider including recruitment efforts through advertisements, contact with the State Nurses Association, contacts with Visiting Nurse Associations for services by arrangement, and schools of nursing, and personnel policies that are competitive with hospitals and other facilities in the community.

SURVEY PROCEDURES

When the surveyor recommends a waiver, the following documentation is required in the explanatory statement column of the survey report form, 405.1124:

1. An assessment of the extent to which the facility is making the best use of its resources to improve the quality of care it furnishes, and an assessment of the health and safety implications of all deficiencies;

2. A statement indicating that the provider is in an area which has been determined to have an existing or anticipated bed supply problem, e.g., pending termination or non-renewal actions;

3. Names and addresses of other participating skilled nursing facilities in the area as well as:

   a. Distance and normal driving time, road conditions, etc. to other skilled nursing facilities; and

   b. Average daily occupancy rate of other participating skilled nursing facilities;

4. A description of the method established for assuring the availability of a registered nurse or physician during the 48 hour period, and an assurance that they spend such time as is necessary at the facility; or

5. A statement that all patient records have documentation by the attending physicians that the patients do not require the services of a registered nurse for a 48 hour period;

STANDARD	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
(4) Such facility has made and continues to make a good faith effort to comply with the more than 40-hour registered nurse requirement, but such compliance is impeded by the unavailability of registered nurses in the area.	3. The attending physicians have documented that all patients in the facility do not require the services of a registered nurse over a 2-day period; or the facility has arranged for the necessary coverage by a registered nurse or physician when such services are required.	6. An evaluation of the good-faith efforts of the provider to comply with the 7-day RN coverage including a narrative statement as to: a. The availability of registered nurses in the area; b. The provider's attempt to employ additional registered nurses; and c. The comparison of the salary and benefits offered by provider and the community scale.

STANDARD

(b) Waiver of medical director requirement. To the extent that § 405.1122 requires any skilled nursing facility to engage the services of a medical director either part-time or full-time, the Secretary may waive such requirement for such periods as he deems appropriate if, based upon documented findings of the State agency, he determines that:

(1) Such facility is located in an area where the supply of physicians is not sufficient to permit compliance with this requirement without seriously reducing the availability of physician services within the area, and

(2) Such facility has made and continues to make a good faith effort to comply with § 405.1122, but such compliance is impeded by the unavailability of physicians in the area.

INTERPRETIVE GUIDELINES

The medical director requirement may be waived after December 31, 1975 if the following conditions are present:

1. The facility meets the rquirements for physician participation as set forth in 405.1121(1) Patient Care Policies, 405.1123 Physician Services, 405.1127(d) Pharmaceutical Services Committee, 405.1135(a) Infection Control Committee, and 405.1137 Utilization Review.

2. The facility is located in an area where the denial of a provider would seriously limit beneficiaries' access to services. In making this determination the following should be considered:

   a. Location of other providers in terms of topography of the surrounding community; e.g., mountainous terrain; the absence of safe, efficient, and regularly available transportation; and the existing medical care pattern;

   b. Existing bed shortage in the community is determined by reference to the occupancy rates and waiting lists in the participating skilled nursing facilities; and

   c. Evidence of good faith on the part of the provider, including recruitment efforts through advertisements, and contact with the local, county, and State medical associations and local hospitals.

SURVEY PROCEDURES

When the surveyor recommends a waiver, the following documentation is required in the explanatory statement column of the survey report, 405.1122:

1. Assessment of the availability of physicians in the area;

2. A statement indicating that the facility is in an area that has been determined to have an existi or anticipated bed supply problem, e.g., pending termination or nonrenewal actions;

3. Name and addresses of other participating skilled nursing facilities in the area as well as:

   a. Distance and normal driving time, road conditions, etc., to other skilled nursing facilities; and

   b. Average daily occupancy rate of other participating skilled nursing facilities.

4. An evaluation of the good-faith efforts of the provider to comply with the medical direction requirement including a narrative statement as to:

   a. Contacts with local and State medical associations (see 405.1122);

   b. Investigation of possible agreement with nearby hospital;

   c. Recruitment efforts through advertisements in medical journals, etc.; and

   d. Attempts to recruit a medical director are initiated upon publication of this regulation.

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